DOCUMENT RESUME

ED 262 858 PS 015 029

AUTHOR Hubbell, Ruth; Barrett, Barbara
TITLE Parent-Child Center Short-Term Assessment Study. Final Report.
INSTITUTION CSR, Inc., Washington, D.C.
SPONS AGENCY Office of the Assistant Secretary for Planning and Evaluation (DHHS), Washington, D.C.
PUB DATE 20 Aug 84
NOTE 96p.
PUB TYPE Reports - Descriptive (141) -- Reports - Evaluative/Feasibility (142)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS Administration; Delivery Systems; Health Services; *Infants; *Intervention; *Low Income Groups; Parent Education; Parent Participation; Personnel; Preschool Education; Program Content; Program Development; Program Effectiveness; *Program Evaluation; Program Improvement; *Program Validation; Social Services; *Toddlers
IDENTIFIERS *Parent Child Centers

ABSTRACT

A short-term descriptive assessment, this study provides summary data on the Parent-Child Center (PCC) comprehensive early childhood intervention programs initiated in 1967 and operated by the Administration for Children, Youth, and Families. PCCs provide low income families with children under three with social service, health, and educational assistance. The assessment (1) reviews and synthesizes research literature on PCCs, (2) collects descriptive information on all PCCs, (3) assesses in-depth nine PCCs to obtain comprehensive program and client data, and information concerning best practices, and (4) presents options for future program evaluation and monitoring. All information was tabulated and analyzed to assess program practices against indicators of program quality; to describe program strengths and weaknesses; and to identify future program options. Areas covered in the study include methodology; findings (particularly those affecting the community and the organization), education components; health, nutrition, and social services; comparison of critical program variables for early intervention programs and PCC programs (particularly, variables of the grantee or operating agency, program direction and staff, delivery system, center-based program, length of program intervention, parent involvement and education, health and social services, program strengths and "best practices," and program changes desired and limitations on effectiveness); and conclusions. An appendix lists the names and locations of all Parent Child Centers. (DST)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

2169

PS

ED262858

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

X The document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

August 20, 1984

FINAL REPORT

PARENT-CHILD CENTER
SHORT-TERM ASSESSMENT STUDY

Prepared for:

Dr. Tom Hertz
Project Officer
Office of the Assistant Secretary
for Planning and Evaluation
Department of Health and Human Services
Washington, D.C. 20201

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Ruth Hubbell

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Prepared by:

CSR, Incorporated
Suite 500
805 15th Street, N.W.
Washington, D.C. 20005

PS 015029

ACKNOWLEDGMENTS

The project team greatly appreciates the valuable contributions to this project made by numerous individuals. First, we acknowledge the overall guidance provided by Dr. Tom Hertz, the Government Project Officer during the design, implementation and analysis phases of the study. Mr. Rick Johnson, PCC Chief, ACYF, was extremely generous with his time and knowledge of the program. Dr. Lisa Sherwood-Farber and Mrs. Lucy Conboy, ASPE, provided additional direction and suggestions. The ASPE/ACYF work group members were helpful and probing in their reactions to and recommendations for the study.

ACYF Regional Office staff, particularly in Philadelphia and Atlanta, contributed much to our understanding of local program operations and challenges.

The directors, staffs, and families, of all nine PCC's visited, as well as their grantees, were most gracious, informative and generous with their time and assistance. The directors of the 27 PCC programs contacted by telephone also were very willing to participate in lengthy discussions with candor.

We also appreciate the contributions made by the ten early childhood intervention scholars listed in Appendix B, who assisted us in the identification of the program quality indicators.

Project staff who contributed significantly to the design and conduct of the study are identified on the following page. Other CSR, Incorporated staff who deserve special mention for their support in preparing the report include our word processors Donna Oelberg, Ted Fambro, Carla Replogle and Margo Ross.

AUTHORS

Ruth Hubbell
Barbara Barrett

PROJECT STAFF

Project Director: Sherrie Aitken, D.P.A.
Associate Project Director: Ruth Hubbell, Ph.D.
Senior Analysts: Barbara Barrett,
Ann Gilman-Dawson, Ed.D., and Cynthia Mikel
Research Assistants: Cathy McConkey
Dan Michael

TABLE OF CONTENTS

	Page
CHAPTER I. EXECUTIVE SUMMARY	1
A. ADMINISTRATION, COSTS, POPULATION SERVED	1
B. EDUCATIONAL SERVICES FOR CHILDREN AND PARENTS	2
C. PARENT EDUCATION AND INVOLVEMENT	2
D. HEALTH SERVICES	3
E. SOCIAL SERVICES	3
F. COMPARISON OF QUALITY INDICATORS TO PROGRAM OPERATION	4
G. BEST PRACTICES	5
H. CONCLUSIONS AND RECOMMENDATIONS	5
CHAPTER II. INTRODUCTION AND METHODOLOGY	8
A. INTRODUCTION	8
1. Background of PCC's	8
2. Purpose and Approach of Study	8
B. METHODOLOGY	9
1. Background Report as the Basis of Study Design	9
2. Sample Selection	10
3. Data Collection	11
4. Analysis	12
CHAPTER III. FINDINGS	13
A. COMMUNITY AND ORGANIZATIONAL FACTORS	13
1. Community Descriptors	13
2. Organization and Management	13
3. Population Served	16
4. Costs	25
5. Personnel	30
6. Summary of Community and Organizational Factors	37
B. EDUCATION COMPONENT	37
1. Center-based Programs	37
2. Home-based Programs	43
3. Parent Education and Involvement	47
4. Parent Involvement	48
5. Summary of Educational Component	49
C. HEALTH SERVICES	50
D. NUTRITION SERVICES	52

TABLE OF CONTENTS (continued)

	Page
E. SOCIAL SERVICES	52
F. SUMMARY OF HEALTH AND SOCIAL SERVICES	55
CHAPTER IV. COMPARISON OF CRITICAL PROGRAM VARIABLES FOR EARLY INTERVENTION PROGRAMS TO PCC PROGRAMS	56
A. GRANTEE OR OPERATING AGENCY	56
1. Amount of Bureaucracy and Support of Bureaucracy for the Program	56
2. Security and Adequacy of Funding for Program Operations	57
3. Program Location and its Relation to Characteristics of Population Served, Service Availability, Facilities, Travel Time	57
B. PROGRAM DIRECTION AND STAFF	57
1. Control of Program - Policy Council Activity and Size	57
2. Staff-child Ratio	58
3. Training and Characteristics of Director	58
4. Staffing Model and Ratio of Professionals to Paraprofessionals	58
5. Staff Training	59
6. Staff Turnover	59
7. Proportion of Paraprofessionals to Professional Staff	59
8. Sensitivity to Family Needs, Attitudes Toward Families	59
C. DELIVERY SYSTEM	59
1. Number and Length of Home Visits	60
2. Number of Contact Hours with Child Only, Parent Only, and Parent-Child Together	60
3. Time Devoted to Service and to Other Activities	60
D. CENTER-BASED PROGRAM	60
1. Classroom Organization and Materials	60
2. Adult-Child Verbal Interaction	61
3. Child-initiated Activities	61
4. Developmentally Appropriate Activities	61
5. Patterns of Adult/Child Activity and Control	61

TABLE OF CONTENTS (continued)

	Page
6. Affective Environment	62
7. Treatment of Parents and Children Together	62
E. LENGTH OF PROGRAM INTERVENTION	62
1. Age at Enrollment and Number of Years' Intervention	62
2. Number of Months Enrollment Per Year	62
F. PARENT INVOLVEMENT AND EDUCATION	
1. Attendance and Activities	63
2. Improvement in Family Life Status	63
G. HEALTH AND SOCIAL SERVICES	63
1. Provision of Health Services	63
2. Nutrition-Provision of Meals	64
3. Social Services Availability, Staffing and Types of Services	64
H. PROGRAM STRENGTHS AND BEST PRACTICES	64
1. PCC Staff Perceptions About Program Strengths and Benefits to Participants	64
2. Best Practices Identified by CSR	67
I. PROGRAM CHANGES DESIRED AND LIMITATIONS ON EFFECTIVENESS	71
1. PCC Staff Perceptions About Program Changes Desired	71
2. Limitations on Program Effectiveness Identified by CSR	74
CHAPTER V. CONCLUSIONS	79
A. COMMUNITY AND ORGANIZATIONAL FACTORS	79
1. Population Served	79
2. Organization and Management	80
B. EDUCATION COMPONENT	81
C. PARENT EDUCATION	81
D. HEALTH SERVICES	82
E. NUTRITION	82

TABLE OF CONTENTS (continued)

	Page
F. SOCIAL SERVICES	82
G. PARENT INVOLVEMENT	83
H. PCC GUIDELINES	83
I. PROGRAM EVALUATION AND MONITORING	83
APPENDIX A	85
APPENDIX B	88

CHAPTER I.

EXECUTIVE SUMMARY

Parent Child Centers (PCC's) are comprehensive early childhood intervention programs initiated in 1967 and operated by the Administration for Children, Youth, and Families. They are designed to enhance the development of children under three years of age and to strengthen their parents as their primary educators. PCC's provide low-income families with social service, health, and educational assistance. Little systematic information currently exists on the Parent Child Centers at the Federal level. Therefore, the Office of the Assistant Secretary for Planning and Evaluation contracted with CSR, Incorporated to conduct a short-term descriptive assessment of the 36 PCC's.

CSR reviewed written program descriptions included in the grant applications and other documents submitted by the Parent Child Centers. To supplement this record review, CSR collected information from 27 of the PCC directors by telephone and from nine of the PCC's on-site. All of this information was tabulated and analyzed to provide summary descriptive data on all programs; to assess program practices against indicators of program quality; to describe program strengths, weaknesses and "best practices"; and to identify future program options.

A. ADMINISTRATION, COSTS, POPULATION SERVED

The Parent Child Centers served 4,500 children at a total cost (including the non-federal share) of $15.5 million in FY 83. About half of the programs are urban and half are rural. Each program serves families of primarily one race, with 45 percent black, 20 percent white, 17 percent Hispanic, and 10 percent other minorities, including Eskimo, Hawaiian, and Native American.

The programs generally are part of a community action or other grantee agency and usually are closely affiliated with Head Start programs--sharing facilities, staff, or other resources. A few programs are experiencing serious management problems, usually related to personnel or facilities difficulties.

The average PCC family is one headed by a single minority mother, under 30 years of age, having less than a high school education, and supported by public assistance with an income of less than $5,000 a year. In addition to the child under three in the PCC, she is likely to have at least one other child. The PCC's serve few pregnant women. The children served are most frequently two-year-olds (33%); one-year olds (27%), and infants under a year (19%). Some older children, usually siblings of the target group, are also served.

A surprisingly high percentage of families drop out of the program each year. Site-visit programs reported turnover rates of 13 to 333 percent of total enrollment. Primary reasons for drop out are the requirements of the program for parent participation and family mobility.

The average total cost is $3,529 per child and $4,402 per family. This figure includes the non-federal share. Costs vary widely across programs and there is little relationship between numbers of children served and total cost. As expected, the cost per child does decline with increasing program size. Cost per child has increased only $819, or 23 percent, since 1969.

No excessive costs were identified. Staff, especially teacher aides, generally are paid low salaries. Over a quarter of the staff are current or former FCC parents, and several programs have special training and employment provisions for parents.

Staffs reflect the racial makeup of client families and there is very little staff turnover. About a quarter of the staff are professionals, and these are usually directors and component coordinators. While there is a hierarchical structure between the coordinators and direct service staff, a team approach is frequently observed in the classrooms. Few staff members have professional training in child development; most have obtained it on-the-job.

B. EDUCATIONAL SERVICES FOR CHILDREN AND PARENTS

Almost all FCC's provide educational services to children in a center-based program; many also provide developmental services using home visitors. Children usually attend the center two-to-three days a week participating in a variety of developmental activities. These activities are based on a range of curricula. Activities are designed to enhance cognitive, socio-emotional, and physical development. Often, the activities observed were inappropriate for the developmental level of the children.

Most centers observed had a positive affective level, but there were inadequate amounts of language interaction between teachers and children. Classrooms sometimes were not well-organized, especially lacking space between activity areas. Facilities are often inadequate, severely constraining the program in several centers.

Child-staff ratios are higher than the FCC Guidelines recommended levels for the ages of the children, and class sizes are larger than recommended levels in over a third of the programs.

The home-based educational services observed were excellent, with appropriate activities, a focus on the parent-child dyad, collegial relationships with parents and instructions for parents on how to continue activities between visits.

C. PARENT EDUCATION AND INVOLVEMENT

The FCC programs emphasize parental education and development. The majority identified parenting skill development and emotional development as central goals for the parent education program. A third of the programs

also focus on educational or employability development to assist parents in achieving economic self-sufficiency.

PCC's provide a variety of activities toward these ends, including classes and workshops in child development, home management, health, nutrition, high school equivalency education, and job training. A combination of traditional and participatory educational techniques are used, although the classroom-oriented approaches predominate. However, the observed parent group interaction usually was quite active and mutually supportive.

Parent attendance at the center is required by most, but not all, programs. Similarly, parent-child interaction is a part of the program in the majority but not all PCC's. The level of interaction and instruction of parents by staff during such sessions varied widely across and within programs. In some cases, parent-child interaction was a learning experience in which parents, children, and teachers were actively involved; in others, parents passively observed.

Parents may also be involved in the PCC as decision-makers. According to the Head Start regulations which apply to PCC's, each program should have a Policy Council, composed of at least 50 percent parents. All but two of the PCC's have such councils, but there is considerable variability across the councils in the level of involvement and roles assumed by parents.

D. HEALTH SERVICES

The PCC's provide medical and dental screening to children, and in some cases, to parents. Medical treatment is generally available through referral agencies. The national average for completing medical examinations is higher for Head Start programs than for PCC's. PCC's often do not complete the medical examinations until late in the year.

Most programs provide at least two meals a day to children and the majority also provide meals to parents. Staff consider the meals an important part of family nutrition for both their contributions to dietary intake and family nutrition education.

Diapering and toileting procedures were observed on site in the nine PCC's visited. In the majority of these programs, standards were not adequate to prevent the spread of disease according to research on this topic.

E. SOCIAL SERVICES

Social service staff provide a variety of services to families, such as direct counseling, emergency assistance, and referral to other community resources. Family needs assessments are usually conducted early in the year.

F. COMPARISON OF QUALITY INDICATORS TO PROGRAM OPERATION

A literature review and discussions with leading early intervention researchers were completed to identify key indicators of quality in programs for young children. These indicators were compared with data collected from all 36 programs. Telephone discussions and site visits focused on the extent to which these indicators were present in the 36 programs.

Overall, the PCC's performed well on the following indicators:

- sensitivity of staff to families;
- quality of home visits;
- employment of parents as staff;
- amount of time devoted to serving families;
- earlier age at enrollment;
- affective environment;
- patterns of adult/child interaction and control;
- group educational activities for parents;
- social services provision and referral;
- organizational support for the program;
- use of community resources; and
- employment of paraprofessionals.

Overall, PCC's did not perform as well on the following indicators, although there were some outstanding exceptions:

- adequate and appropriate facilities;
- classroom arrangement;
- developmentally appropriate activities;
- parent-child interaction in classrooms;
- adult/child verbal interaction;
- length of intervention (family drop-out rates);
- child-staff ratio;

- o Policy Council involvement with program; and
- o provision of health services.

G. BEST PRACTICES

CSR reviewers identified a number of innovative and outstanding approaches used by the programs visited. These practices could be adopted by other programs to strengthen their own efforts. They include:

- o written parent participation agreements;
- o parent/child interaction approaches;
- o use of community businesses for program support;
- o coordination with other agencies for provision of parent education services;
- o model classroom and teacher behaviors;
- o social services tailored to a unique target population;
- o large numbers of parents employed as staff;
- o participatory parent education activities, such as as sewing classes;
- o active, involved Policy Council;
- o excellent mainstreaming of handicapped children;
- o effective use of volunteers; and
- o strong educational and career development program.

H. CONCLUSIONS AND RECOMMENDATIONS

In general, the Parent Child Centers exemplify many of the quality characteristics associated with effective child development programs with strong parent education components. They are serving a large number of children and families at reasonable cost. Many innovative approaches are used to respond to local needs and there is a clear emphasis on moving families out of dependency. Programs often operate under less than adequate conditions and are able to do so because they have highly dedicated staff. While there are problems, appropriate training, technical assistance, and implementation of proposed regulations can correct most of them.

Based on data collected, review of the quality indicators, and self-evaluations by the programs, the following program options are suggested.

1. Efforts should be made to reduce family turnover; such efforts could include participation contracts, targeting a less transient client population, concentrating services to families at enrollment, and requiring completion of physical exams prior to enrollment. On the other hand, families should not be allowed to remain in the program for over three years, in order to allow a larger number of families to participate.

2. Regional office staff should review those PCC's experiencing management problems, and, if possible, provide technical assistance.

3. Training should be provided to all staff regarding education of parents and techniques for assisting them in the development of parenting skills. Specific training is also needed if staff are to work with abusive and neglectful parents. Finally, teachers and aides should be trained in the development of infants and toddlers as well as in appropriate goals, techniques, and activities for these children.

4. Staff size should be increased or enrollment reduced to yield appropriate child-staff ratios. Class size should be reduced to appropriate standards where it exceeds recommended levels.

5. Assistance should be provided to help programs with inadequate facilities to relocate.

6. Sanitary policies which meet recommended standards should be established for child diapering and toileting. Staff training in the need for such procedures should be provided as well.

7. Parent/child interaction sessions of at least an hour per day of attendance should be implemented. Teachers should actively educate parents about child development during this period.

8. Parent education activities should reflect parents' needs and interests and should use participatory techniques as much as possible.

9. Parent participation requirements should be instituted in all PCC's.

10. Health services should be provided more completely and earlier in the program year.

11. Needs assessments should be conducted at enrollment, updated periodically, and should be goal-oriented.

12. Policy Councils should be established in all PCC's and should adhere to recommended activities and responsibilities.

Additional Suggestions for Program as a Whole

1. The proposed PCC Program Guidelines are very comprehensive and, if promulgated, would address most of the identified program deficiencies.

2. A complete descriptive and impact evaluation of all PCC's should be conducted to determine their immediate and long-term effects on children and families.

3. Many PCC's have model components that should be shared with the other programs. A national conference focusing on these "best practices" would assist in the transfer of these approaches across PCC programs and Head Start migrant programs as well.

4. Large expansion of the program to additional communities is not recommended until some of the problems cited here have been addressed by training and technical assistance.

5. If, in the future, Head Start programs are offered the option to expand by initiating a PCC, care must be taken to ensure such programs are specifically designed for infants and toddlers.

CHAPTER II.

INTRODUCTION AND METHODOLOGY

A. INTRODUCTION

1. Background of PCC's

The Parent Child Centers (PCC's) were initiated in 1967 within the (now) Administration for Children, Youth, and Families as a part of the Head Start program to provide early intervention and developmental services for economically disadvantaged families with children under three years of age. PCC's differ from regular Head Start programs on two key dimensions: (1) they serve younger children, primarily infants; (2) they work more extensively and directly with parents. There are presently 36 PCC's located throughout the country, in both urban and rural communities, serving approximately 4,500 children at a cost of $15.5 million in FY 83. These PCC's have evolved and developed their services in response to local needs and resources, and as a result, are a diverse group of programs. (See Appendix A for a listing of the PCC's.)

The policy focus of the Administration for Children, Youth, and Families (ACYF) is reflected in the two primary goals of the PCC program:

- to bring about very early stimulation for young children and to involve them in educational activities so that they may develop to their fullest potential; and

- to strengthen the roles of parents and the family in the development of the child by focusing on the parents as the primary educators of their children.

These program emphases have led PCC's to be a source of strategies for fostering early childhood development and models for planning family service programs.

2. Purpose and Approach of Study

The purpose of this assessment is to provide Health and Human Services (HHS) with current information on PCC operations. For the most part, PCC's have not participated in much of the monitoring and information collection regularly conducted by ACYF with standard Head Start programs. Performance Standards for PCC's have never been finalized. Consequently, comparatively little systematic information is available about the programs at the Federal level.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with CSR, Incorporated to conduct a descriptive study

of the Parent Child Centers. The information developed will be available to policymakers and program managers for a variety of uses, such as making program improvements, considering options for expansion of services to children under three and their families, and developing plans for transferring best practices across PCC programs and Head Start migrant programs.

The study involved the following tasks:

(a) A review and synthesis of the research literature on PCC's and other programs designed to serve parents and children under three to determine critical program variables that relate to program effectiveness.

(b) The collection of general descriptive information on all 36 Parent Child Centers through written reports and telephone discussions.

(c) The in-depth assessment of nine Parent Child Centers to obtain comprehensive program, client, and "best practices" information. This assessment focused on services provided, family characteristics, management structure and costs, staff characteristics, and community relationships.

(d) The presentation of options for future program evaluation and monitoring, program improvement, and services to children under three.

B. METHODOLOGY

1. Background Report as the Basis of Study Design

In order to focus the study on program factors that most closely relate to positive effects, CSR developed a series of proxy indicators of program quality. These indicators, such as staff-child ratio, amount of verbal interaction between staff and children, and affect level in the classroom, were developed from two sources. First, a review of the early intervention research literature was made. Second, telephone discussions with ten well-known researchers in this field were conducted. These discussions were designed to obtain professional insights on the critical program factors related to the development of children and parents. The individuals contacted are listed in Appendix B.

The indicators obtained from these two sources were used to develop the discussion and observation guides for PCC program assessment. The literature review and the findings from the telephone discussions are contained in a report entitled "Background Report for Parent Child Center Short-Term Assessment."

Results of the comparisons of program operations to these indicators are presented in Chapter IV.

2. Sample Selection

There are 36 Parent Child Centers located across the country. All of these provided data for the study through their submission of written reports.

Twenty-seven of the programs provided additional information through telephone discussions with CSR staff. Nine programs were purposively selected for on-site visits to obtain in-depth descriptions of a sample of programs. CSR, ASPE, and ACYF Federal and Regional staff collaborated in the selection of this sample.

The following criteria were used to select the nine sites:

- Geographic distribution across the HHS Regions
- A mixture of urban/rural programs
- A mixture of different racial groups served by the programs
- Variation in program model (center-based, home-based)
- Inclusion of one former Parent Child Development Center
- A mixture of types of grantee organizations.

The sample was revised several times because some of the programs originally selected were undergoing major administrative changes. The final nine selected include:

- Philadelphia Parent Child Center, Inc.
  Philadelphia, Pennsylvania
- Parent Child Center-Southwestern CAC, Inc.
  Huntington, West Virginia
- Louisville-Jefferson County CAA Parent Child Center
  Louisville, Kentucky
- Breckinridge-Grayson Programs Parent Child Center
  Leitchfield, Kentucky
- Urban League Parent Child Center
  New Orleans, Louisiana
- Oakland Parent Child Center
  Oakland, California
- Development of Human Resources
  Grandview, Washington

- o West CAP Preschool Education Program
  Glenwood City, Wisconsin

- o Garfield Parent Child Center
  Chicago, Illinois

3. Data Collection

The data collection effort for the 36 PCC's included two phases. First, all programs were asked to submit a number of documents to CSR, including:

- o Most recent grant application
- o Component plans
- o Current ACYF budgets
- o Four most recent quarterly fiscal reports
- o Program self-assessments and grantee improvement plan (developed within past three years)
- o Regional Office monitoring reviews (conducted within past three years)
- o Family demographic data

A data form was developed to extract items describing program operation. This information was obtained by reviewing written materials and conducting telephone or in-person interviews with staff. The information contained in these forms is summarized and analyzed in Chapter III.

Site visits of two to three days were conducted with nine PCC's. Teams of two or three CSR staff members visited each program in February and March, 1984. Interview guides were developed and interviews were conducted with the following types of respondents:

- o Grantee director
- o PCC Director
- o Education Coordinator
- o Health Coordinator
- o Nutrition Coordinator
- o Social Services Coordinator
- o Policy Council Chairperson
- o Representative of a community agency that works with the PCC

Questions in the personal and telephone discussion guides were generally open-ended. Thus, respondents gave the most salient information from their perspectives. For example, education coordinators were

asked what the educational goals of the program were. They responded with a number of items which may differ across PCC's. Thus, our findings are presented as respondent "reports" rather than as counts from a pre-designed checklist.

Budget and staff characteristics were reviewed with the Director and/or bookkeeper. Center-based and home-based programs for children and parent involvement/education program were observed. The Early Childhood Environment Rating Scale developed by Thelma Harms and Richard Clifford guided the center observations. Criteria from the proposed PCC Program Guidelines and the background report guided observations of the home visit and parent programs.

The proposed PCC Program Guidelines were used to guide a review of a 10 percent sample of health records, social service records, and individual plans for children. When possible, Policy Council meetings were observed and informal conversations were held with parents and teachers.

Information from all of these sources was used to develop individual site reports.

4. Analysis

Quantitative data for all 36 sites were tabulated. Non-quantitative data items were reviewed to determine common elements and themes. Categories were developed from these items and were then used to classify and tabulate this information. For example, stated educational goals for children were distributed into such categories as language, concept development, etc.

On some key variables, data are presented separately by the 9 sites and the 27 sites to assess the representativeness of the programs visited. Also, some data were collected only on-site and these are presented separately.

CHAPTER III.

FINDINGS

The Parent Child Centers are a diverse group of programs located throughout the country. The number of children served per program ranges from 72 to 216 and ACYF grants range from $223,291 to $557,300. PCC's are comprehensive service programs that provide educational services in centers or through the provision of educational information by home visitors. Health screening and treatment, social services, parent educaton services, and nutrition services are provided to the families as well. The delivery systems for all of these services have developed to meet the needs and resources of the local communities.

The presentation of the study findings which follows is organized by these various components. It begins with a description of the organizational and community contexts and characteristics of the programs, then proceeds through the various components. It then relates these findings to the program quality factors identified in the Background Report and identifies strengths, weaknesses, and best practices. The report concludes with summaries of the findings and options for the direction of the program. Individual descriptions of the 36 programs are contained in Volume II of this report.

A. COMMUNITY AND ORGANIZATIONAL FACTORS

1. Community Descriptors

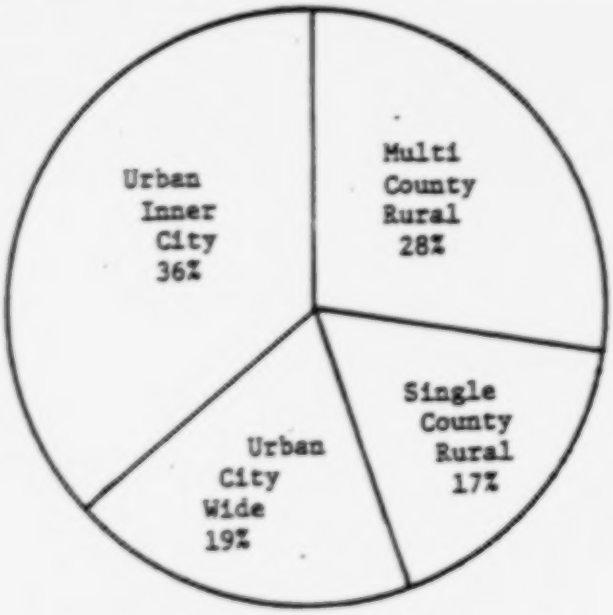
Urban/rural distribution of the PCC's was determined by catchment area served by the programs. As shown in Exhibit 1, the PCC's are almost equally split between urban and rural programs. Fifty-five percent of the PCC's are urban, with nearly twice as many of these PCC's serving a specific inner city area (36%) compared to a citywide area (19%). Among the 45 percent of the programs classified as rural, more have a multicounty (ranging from 2-7 counties) than single-county catchment area (28% vs. 17%). The nine site visit programs were representative of the other 27 on the urban/rural dimension.

2. Organization and Management

Program Account 25 (PCC) monies are awarded to community agencies (called grantees) to operate the program at the local level. In some cases, grantees in turn delegate the actual operation to another agency. PCC's typically are operated by the grantee (53%) or by the delegate agency (22%). Less common is the situation wherein the PCC incorporates as a single/limited purpose or private, nonprofit agency to become its own grantee (22%) or delegate (3%).

EXHIBIT 1

GEOGRAPHIC DISTRIBUTION OF PCC PROGRAMS



Types of grantee agencies vary, although the majority of Parent Child Centers are operated by community action agencies (56%). Other types of grantees include the single-purpose agencies mentioned above (11%), local governments (11%), a school district or Indian tribe (3% each) and others (17%), such as educational institutions and nonprofit organizations (see Tables 1 and 2).

TABLE 1

GRANTEE/DELEGATE AGENCY STATUS

Category	N	Percent
Its own grantee	8	22
Its own delegate agency	1	3
Operated by grantee	19	53
Operated by delegate agency	8	22
Total	36	100

Sixty-seven percent of the PCC's are affiliated with Head Start programs. Indeed, they are often closely intertwined with facilities, resources, and staff. A third share facilities; 31 percent have the same director; 25 percent share resources, and 14 percent share coordinators. Half of the programs share some other effort (see Table 3).

TABLE 2

TYPE OF GRANTEE/DELEGATE AGENCY

Type of Agency	Number of Grantees	Percent of Grantees	Number of Delegate Agencies	Percent of Delegate Agencies
Community Action	20	56	0	0
Local Government	4	11	0	0
School District	1	3	0	0
Single/Limited Purpose	4	11	2	25
Indian Tribe	1	3	0	0
Other:	6	17	6	75
Private Nonprofit	(3)	(8)	(3)	(40)
Education Foundation or Private Education	(2)	(6)	(0)	(0)
State Junior College	(1)	(3)	(0)	(0)
Religious Nonprofit Social Welfare	(0)	(0)	(1)	(13)
Private Social Work	(0)	(0)	(1)	(13)
Private Hospital	(0)	(0)	(1)	(13)
Total	36	101	8	100

The management structure, or lines of authority, from grantee to center level is influenced by 1) the number of agencies through which funds pass to operate the PCC program, and 2) the presence of a Head Start program also run by the agency. The latter may introduce another layer in the management structure. Three types of management structures emerge in examining the lines of authority found in PCC programs (see Exhibit 2). Although this schema is somewhat oversimplified, it essentially counts the number of management tiers separating the grantee's Executive or Program Director and the PCC component (e.g., education, health) coordinators or, where there are multiple centers, the Center Directors.

The first and least complex structure involves 6 of the 8 PCC's who are their own grantee (17%). The PCC Executive Director usually is located at the center and also functions as the Center Director to whom component coordinators report directly. Two of these grantees operate Head Start programs and the coordinators are responsible for both Head Start and PCC component services.

The second structure is found primarily with PCC's which are operated by the grantee. There is a PCC Director to whom component coordinators (and in a few instances, Center Directors) directly report, but the PCC Director reports either to the grantee's Executive Director or to the grantee's Director of combined Head Start/PCC programs.

TABLE 3

PCC/HEAD START AFFILIATION
(based on 36 programs)

Type of Affiliation Reported*	N	Percent of Mention
Same Director	11	31
Same Facility	12	33
Shared Coordinators	7	14
Shared Resources	9	25
Other	18	50
No Affiliation with H.S.	12	33

*An individual program could have more than one type of affiliation.

Fifty-eight percent of the programs fall in this category. Two PCC's operating as their own grantee are included in this category because they also have Head Start programs through which the PCC is operated.

The third structure supports programs which are delegate agencies or are run by them and a few PCC's where the Head Start program functions as another layer in the line of authority (25%). In these programs, the component coordinators report to the PCC Director, who reports to the delegate agency's Director or the Head Start Director, who in turn reports to the grantee's Executive Director or designate. In essence, there are three different levels separating the component coordinators and grantee director.

The majority of the programs described their relationships with their grantee as generally good to excellent; only 14 percent described them as not good or in transition.

3. Population Served

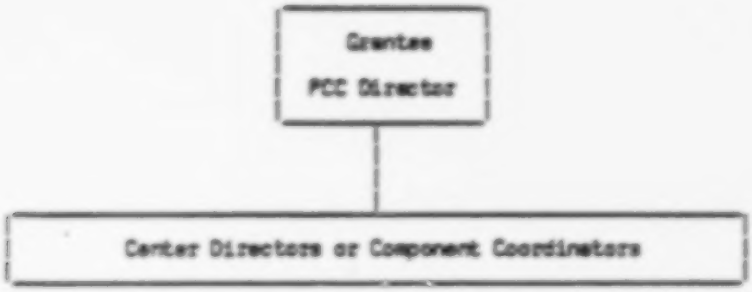
At the time of data collection, the programs were serving 3,624 families with 4,486 children. Because of turnover, many more families receive service during the year.

The PCC's follow the Head Start regulations which stipulate that 90 percent of the enrolled children must be from families receiving public assistance or having incomes below the official poverty lines

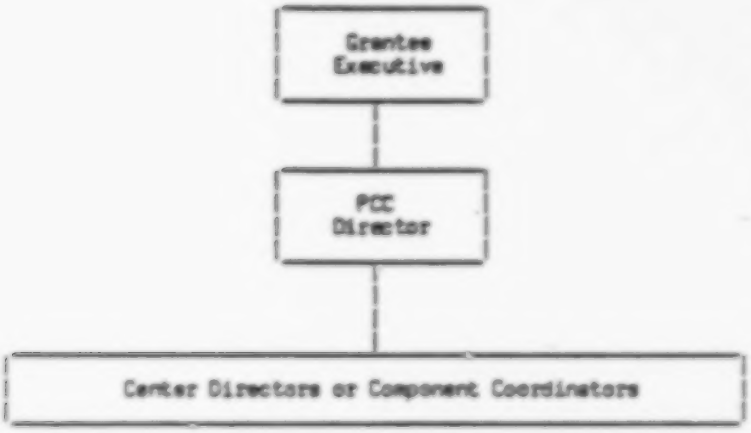
EXHIBIT 2

PCC MANAGEMENT STRUCTURES

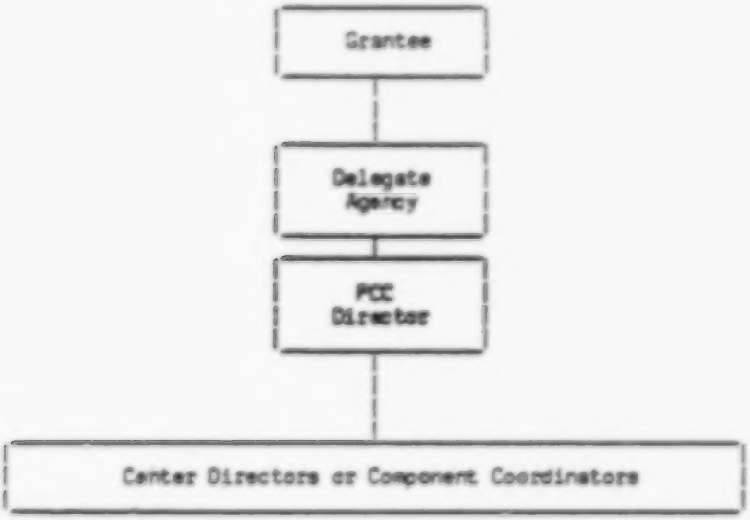
Type I



Type II



Type III



(adjusted for family size). Within the general target population of low-income families, a number of FCC programs have particular populations which they try to serve (see Table 4). Of the 31 programs reporting on target populations, nearly one-third (32%) target pregnant teenagers. Other targeted groups include high-risk families (29% of the programs), single mothers (26%), handicapped children (23%), pregnant mothers (16%), and unemployed families (13%). (Percentages in this report may not always add to 100 because of rounding and/or missing data.) In addition, a number of other categories of targeted families were identified by less than 10 percent of the programs. These include migrants, first or second-time mothers, foster children, protective service referrals, working mothers, middle-aged mothers, rural Eskimos, Indians on one reservation, and families returning from the previous year.

Most programs (92%) identified one or more specific groups who receive priority for enrollment. Half of the FCC's claim to give preference to high-risk/special needs families, and 42 percent to handicapped/special needs children. Pregnant teenagers or pregnant women receive priority in nearly one-third of the programs (31%). Other groups targeted less frequently by the FCC's include referrals from the courts and protective services (22%), single parents (19%), and teen parents or very young mothers (17%). Only three programs (8%) indicated no prioritization because all families who apply are served. To help determine priorities among applicants, some programs (39%) mentioned establishing a hierarchy (usually based on type and severity of need) which may be tied to use of a point system, availability of age slots, and/or length of time on a waiting list.

The greatest number of children served by age group are two-year-olds (33%), followed by one-year-olds (27%) and infants under one year (19%). Older children, usually siblings, are also served, including three-year-olds (13%), four-year-olds (4%), and five-year-olds (1%). The twenty programs reporting service to pregnant mothers enrolled only 162 pregnant women (4% of the total families). (See Table 5.)

Among families, the largest racial group served is black, 45 percent, followed by white, 20 percent, and Hispanic, 17 percent. Other minorities served include Hawaiians, Native Americans, Eskimos, and Asians (see Table 6).

The individual programs are not highly integrated. In 31 programs, at least 75 percent of the families are of the same race. Only in Oakland, Fayetteville, Dallas, La Junta, and Portland are at least 25 percent of the families from a different race than the dominant race in the program.

TABLE 4

TARGET POPULATIONS REPORTED BY PROGRAMS

Target Population	Number of Programs	Percent
Pregnant Teenagers	10	32
High Risk/High Need Families	9	29
Single Mothers	8	26
1st or 2nd Time Mothers	2	6
Unemployed Families	4	13
Low Income	11	35
Pregnant Mothers	5	16
Handicaps	7	23
Other:		5 each
Migrants, Returnees, Foster Children, Immigrants, Protective Service Referrals, Middle Age Mothers, Rural Eskimos, Indians on a Reservation		

Data from 31 programs.

TABLE 5

TOTAL CHILDREN SERVED BY PCC's

Age Group	Total PCC Population N	Total PCC Population %	9 Site Visit Population N	9 Site Visit Population %
0-12 months	835	19	281	23
13-24 months	1,214	27	351	29
25-36 months	1,489	33	360	30
37-48 months	579	13	124	10
49-60 months	195	4	65	5
61-72 months	50	1	19	2
Total	4,486		1,203	

Fifty-four percent of the program mothers are single, while 39 percent are married. The majority (58%) of these mothers have less than a high school degree, while 39 percent have completed high school or some college (see Tables 7 and 8).

The primary source of family income is public assistance (70% of the families), with wages accounting for 22 percent of the families' incomes. Other sources, such as Social Security or unemployment compensation, support six percent of the families (see Table 9).

Based on data from 13 programs, sixty-one percent of the families have incomes under $5,000; 13 percent were under $2,000 a year. Thirty percent have incomes of $5,000 - $9,999, and only 10 percent receive more than $10,000 (see Table 10).

The majority of PCC families (64%) speak English at home, with 16 percent speaking Spanish and five percent some other language (see Table 11).

Most of the mothers are between ages 20 and 29 (63%), 15 percent are under age 20, and 18 percent are 30-39. Only two percent are over 40 years of age (see Table 12).

Thus, the typical PCC family is likely to be headed by a black (or other minority) single mother, fairly young, with less than a high school education, supported by AFDC at an annual income of less than $5,000 a year. She has at least one child under three and may have more children.

It appears that the PCC programs are successful in serving their targeted groups of low-income, unemployed, single-parent, young families. However, although many PCC's target and give enrollment priority to pregnant women, the actual number served is quite low.

In addition to the families served, thirty programs have waiting lists, though only eleven programs reported on the size of their waiting lists. In all, 821 families were counted as awaiting service (see Table 13).

a. Service to Handicapped Children

While 23 percent of the reporting programs noted that they targeted handicapped children, the percentage of handicapped children of the total PCC population enrolled is 6.7 percent. (Head Start regulations require a 10 percent enrollment.) Ten programs serve less than four percent handicapped, and 14 serve five to nine percent. Nine programs serve 10-14 percent, while one serves over 15 percent. Thus, at least two-thirds of the PCC's are serving less than 10 percent handicapped children. (Two programs did not report on number of handicapped; see Tables 14 and 15.)

TABLE 6

RACIAL OR ETHNIC GROUPS OF PCC FAMILIES

Race/Ethnicity	All PCC's N	All PCC's %	9 Site Visits N	9 Site Visits %
Black	1,645	45	434	47
White	733	20	298	32
Hispanic	597	17	174	19
Other	363	10	27	3
Missing	288	8	—	0
Total	3,626*		933	

*Data are sometimes from older than current enrollment. For 2 programs no breakdown was available.

TABLE 7

MARITAL STATUS OF PCC MOTHERS

Marital Status	All 36 PCC's N	All 36 PCC's %	9 Site Visits N	9 Site Visits %	27 Other N	27 Other %
Single	1,946	54	401	44	1,545	57
Married	1,409	39	492	55	917	34
Missing	247	7	9	1	238	9
Total	3,602*		902		2,700	

*Data provided sometimes represented a less recent enrollment or was estimated by program director.

TABLE 8

EDUCATIONAL LEVEL OF PRIMARY CARETAKER

Highest Educational Level Attained	Primary Caretaker N	%
Less than high school	1079	58
High school graduate and higher education	726	39
Missing	42	3
Total	1847	100

Data from 22 programs

TABLE 9

PRIMARY SOURCE OF FAMILY INCOME

Primary Income Source	Families N	%
Public Assistance/AFDC	1912	70
Wages	611	22
Combination of Above	73	3
Other	154	6
Total	2750	101

Data from 29 programs

TABLE 10

FAMILY INCOME

Income Range	Families N	Families %
Less than $2,000	156	13
$2,000-$2,999	188	15
$3,000-$3,999	212	17
$4,000-$4,999	193	16
$5,000-$9,999	368	30
$10,000 or more	119	10
Total	1,236	101

Data from 13 programs

TABLE 11

PRIMARY LANGUAGE SPOKEN AT HOME

Language	Families N	Families %
English	1,734	64
Spanish	405	15
Other	148	5
Missing	414	15
Total	2,701	99

TABLE 12

AGE DISTRIBUTION OF MOTHERS IN PCC

Age	N	%
Under 20	345	15
20-29	1,437	63
30-39	408	18
40 and over	43	2
Don't Know	65	3
Total	2,298*	

*Data from 22 programs (63% of 3,624 PCC families)

TABLE 13

PROGRAM WAITING LISTS

Total Number of Children/ Families on Waiting List	Number of Programs Included in Count
757 children	17
821 families	11
Have list but presently depleted	2
No list for these programs	6
1578 families or children	36

mean = X = 52.6 families or children/program
median = X = 30 families or children/program

The types of handicapping conditions cover a wide range, but as with regular Head Start, the most frequent category is speech impairment (31% of those handicapped children). Also served are children with physical handicaps (14%), health impairment (7%), mental retardation (6%), Down's Syndrome (6%), and a variety of other conditions. Several programs noted the reluctance of health professionals to label very young children as handicapped.

b. Family Turnover

The number of families who drop out of the program during the year was obtained from seven of the nine site-visited programs. It proved difficult to obtain these data from the other 27 sites; many programs do not record the number of drop-outs. Turnover rates ranged from 13 to 333 percent of total enrollment. New Orleans had the most transient population, with over 210 families being served by a 63-family program in one year (see Table 16). Primary reasons for family drop out were parental participation of other program requirements (cited by seven programs) and family mobility (cited by five).

4. Costs

The total ACYF PCC grant monies reported for FY 1983 are $12.29 million. This gives a mean of $341,454 per program with a range of $223,291 (Chatooga) to $557,300 (Oakland). In addition, programs contribute at least 20 percent of their costs as the non-federal share. Most also receive U.S. Department of Agriculture (USDA) funds for food. Thus, the total budget for all programs is $15,558,571. This is a mean of $432,183 per program with a range of $289,903 to $753,771.

Of the ACYF grants, the major expenditure is for staff. An average of 75 percent of funds goes for personnel, but these costs range from 56-89 percent of the budgets. Other expense categories with averages include: rent, repairs, and utilities, 7.3 percent; transportation, 4.4 percent; and ACYF share of food, 1.1 percent (see Table 17).

The cost per child and cost per family were calculated in several different ways (see Tables 18 and 19). Using the total budget, the average cost per child is $3,529, with a range from $1,969 to $5,798. The mean cost per family is $4,402 with a range of $2,570 to $6,979. The cost to ACYF based on PA 25 funds only is a mean of $2,807 per child (range $1,284 - $4,237) and $3,526 per family (range $1393-$5583).

TABLE 14

NUMBER OF HANDICAPPED SERVED BY PCC's

Primary Condition	N	Percent
Down's Syndrome	17	6
Cerebral Palsy	7	2
Blindness	2	1
Visual Impairment	13	4
Deafness	3	1
Hearing Impairment	6	2
Physical Handicap	42	14
Speech Impairment	92	31
Health Impairment	21	7
Mental Retardation	17	6
Serious Emotional Disturbance	12	4
Specific Learning Disabilities	7	2
Other, Multiple	62	21
Total	301	

Percent Handicapped in Total PCC Population = 6.7

TABLE 15

PERCENT HANDICAPPED PER PROGRAM

Percent	Number of Programs	Percent
0-4	10	28
5-9	14	39
10-14	9	25
15	1	3
unknown	2	5

TABLE 16

NUMBER OF FAMILIES WHO LEFT THE PROGRAM
IN EACH OF THE NINE PCC's VISITED

Program Code	Number Left	Period	Number of Months	Percent of Enrollment
1	16	7/83-3/84	6	15
2	54	Last year	11	40
3	10	9/83-3/84	6	13
4	9	Jan. 1984	1	12
5	65	Last year	11.5	90
6	34	Last year	8	30
7	210	Last year	10	333
8	60	This year	8	40
9	43	This year	4	38
Average	56		7.3	68
Median	43		8	38

$$\frac{\text{Average 56 families left in less than 1 year}}{\text{103 average families/PCC turnover/year}} = 54\% \text{ average}$$

TABLE 17

BUDGET BREAKDOWN

Funds	Total	Average/ Program	Range
Total ACYF Grant (PA25)	12,292,352	341,454	223,291-557,300
Total PCC Budget (including non-Federal and USDA shares)	15,558,571	432,183	289,903-753,771

Category	Average Percentage of ACYF Grant	Range	Number of Programs
Staff including benefits	75	56-89	35
Rent, repairs, and utilities	7.3	2-14	35
Transportation (staff, family, and child, including vehicle maintenance and insurance)	4.4	1-12	35
Food (ACYF only)	1.1	0-3	35
Food (ACYF and USDA; % of total budget)	2.4	0-8	35

TABLE 18

AVERAGE COST PER CHILD AND FAMILY

	Number of Children	Number of Families	Cost Per Child		Cost Per Family	
			ACYF Grant	Total Budget	ACYF Grant	Total Budget
Average	124	102	2,807	3,529	3,526	4,402
Range	72-216	52-199	1,284-4,237	1,969-5,798	1,393-5,583	2,570-6,979

TABLE 19

AVERAGE COST PER CHILD AND FAMILY
BASED ON NUMBER OF MONTHS OF SERVICE

Average Costs	Months of Direct Service				
	8-8.9	9-9.9	10-10.9	11-11.9	12
ACYF Cost/Child	2,494	2,923	2,777	2,922	3,308
Total Cost/Child	3,096	3,932	3,642	3,633	4,136
ACYF Cost/Family	3,591	3,581	3,363	3,746	4,007
Total Cost/Family	4,404	4,023	5,386	4,664	5,009

The individualistic nature of the program is reflected by the differences in cost. One might expect that as the number of children served increases, the overall cost increases. This is not the case. There appears to be no relationship between total cost and number of children served. A program serving 72 children costs just about the same as a program serving 162 children.

Cost per child might be expected to vary by length of program year. The programs vary somewhat in the number of months they provide services, with a range from 8 to 12 months (see Table 20). Sixty-seven percent serve families for 10 or 11 months. However, there is no relationship between number of months children are served by a program and the average cost per child or family.

Economy of scale apparently is a major factor in program cost per child; that is, the more children served, the less the cost per child. As Exhibit 3 shows, the general slope of the graphed cost per child is down.

This trend is also reflected in the cost per child contact hour. The number of children in a PCC was multiplied by the number of hours they participated in the program in a year. This figure was divided into the total budget to calculate total cost per child contact hour. One would expect that as number of contact hours increase, total cost would increase. If this were true, the cost per child contact hour would be about the same across programs. This is not the case. The higher the number of total contact hours, the lower the cost per child contact hour. (Total contact hours is the total number of children times the average number of hours of service received per year per program.) Thus, there appears to be more economy associated with more service. For example, a program that serves 60 children in double sessions of three hours each produces more contact hours than those serving one group of 30 for five hours. Again, as Exhibit 4 shows, there is a general downward trend in cost per child with increased contact hours.

5. Personnel

PCC's employ a variety of personnel although the categories across programs are similar. Almost all programs have directors, education, parent involvement, health, and social services coordinators, teachers and/or home visitors, bookkeepers, cooks, drivers, and janitors. Some programs have nutritionists while others contract for this service. Most of the other functions, such as mental health services, are obtained through contract or are donated.

The distribution of staff employed reflect the educational emphasis of the program and the high staffing requirements that child development programs demand (see Table 21). Forty-four percent of the staff in all programs are in the educational component. This includes the teachers, teacher aides, parent educators, and home visitors. The next highest category is administration, with 15 percent of the staff. This

TABLE 20

MONTHS OF DIRECT SERVICE TO FAMILIES

	Number of Months of Direct Service				
	8-8.9	9-9.9	10-10.9	11-11.9	12
Number of programs	3	7	11	13	2
Percent	8	19	31	36	6

Average no. of direct service months = 10.29 (range 8-12)

TABLE 21

DISTRIBUTION OF PCC STAFF BY POSITION AND OTHER CHARACTERISTICS

Staff Position	Total Number	Percent	Percent From 9 Site Visits
Administration	125	15	15
Coordination	123	14	11
Education	374	44	40
Health	30	3	6
Nutrition	56	7	7
Social Services	33	4	4
Parent Involvement	11	1	3
Maintenance	22	3	4
Transportation	33	4	3
Dual Roles	42	5	8
Total	849	100	101
Current or Former PCC Parents	234	28 (range 0-50%)	
Average Staff/Family Ratio	4.57 (range 2.3-9.4)		(Avg. 9 site visits) 4.20 (range 2.3-6.0)

EXHIBIT 3

COST PER CHILD
BY NUMBER OF CHILDREN SERVED
PER PROGRAM

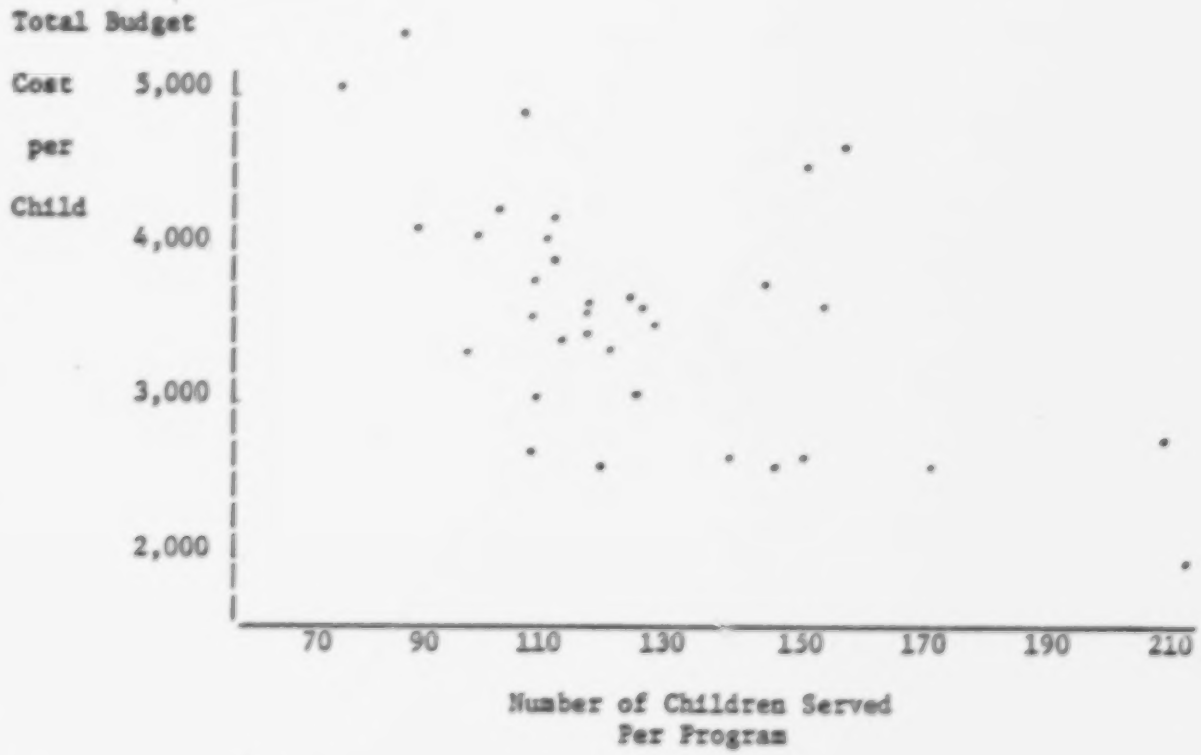
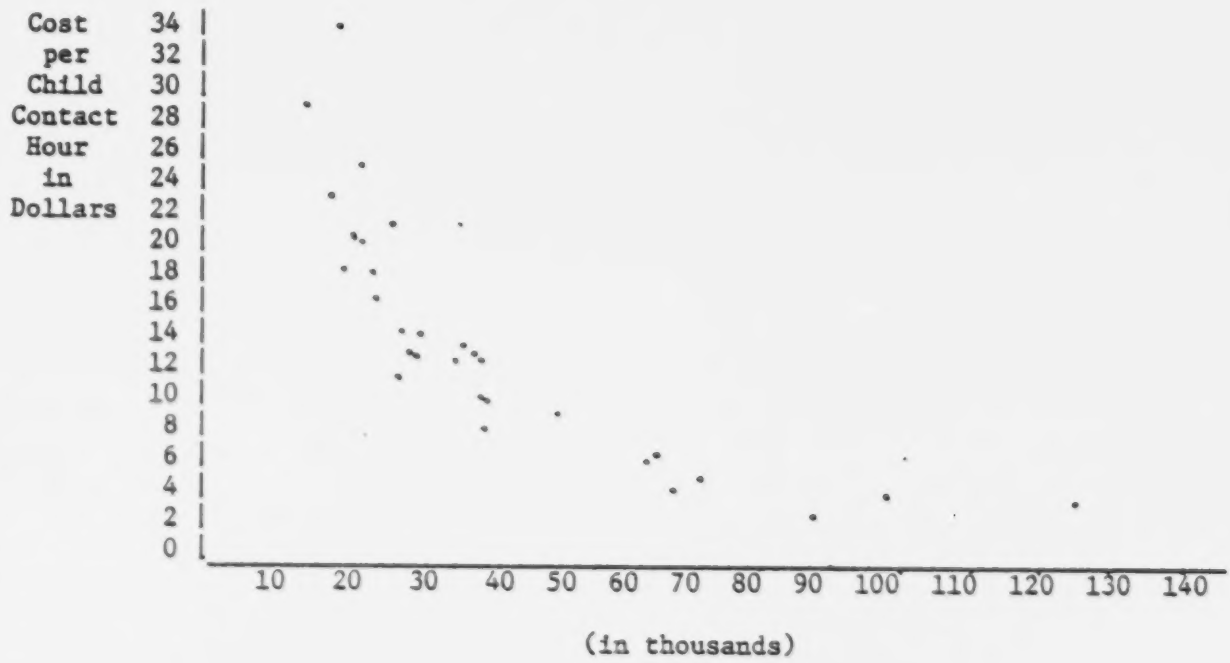


EXHIBIT 4

COST PER CHILD CONTACT HOUR
BY TOTAL HOURS



Total Number of Children Times Average Number
of Hours of Service Received, Per Child
Per Year Per Program

includes directors, assistant directors, secretaries, bookkeepers, and accountants. Coordinators comprise 14 percent of the total staff, including coordinators in the education, health, social services, and parent involvement components. Seven percent of the staff are in the nutrition area, including nutritionists and cooks. Five percent have dual roles. These are usually teacher or social service aide/drivers. Four percent each are social services staff and transportation staff, while three percent each are classified as maintenance and health staff. One percent are parent-involvement staff. However, this is somewhat misleading as parent education and involvement and social service activities are often the partial responsibilities of the education and social services staffs.

As in most child development programs, the staffs are largely female (87%) with 13 percent males. Men are usually clustered in the roles of drivers and janitors, although there are a few male teachers, social services coordinators, and administrators.

The racial composition of the staff overall is somewhat similar to that of the families served (see Table 22). Forty-nine percent (49%) of the staff are black compared to 45 percent of the families; 32 percent of staff are white, compared to 20 percent of the families; 11 percent of staff are Hispanic, compared to 17 percent of the families. Other minorities comprise nine percent of staff and 10 percent of the families. However, racial data were missing on eight percent of the families, so these comparisons are not exact. Individual programs reflected the racial makeup of their client families quite well. Three programs were found to differ by more than twenty-five percent on the dominant racial category and in one of these cases (Dalton), the staff was more integrated than the families. The three programs are listed below:

	Dominant Race in Program	
	Staff	Families
Chattanooga, Tennessee	69% black	97% black
Dalton, Georgia	57% white	82% white
Harbor City, California	52% Hispanic	86% Hispanic

PCC staffs are remarkably stable (see Table 23). Though complete data were available only for the site-visited programs, 83 percent of the staff members had been employed one year or more, 41 percent more than five years, and 24 percent over ten years. Only 11 percent had been employed less than one year. Almost every program visited had some staff who had been with the program since its beginning.

The programs employ many paraprofessional staff members, but employees with college degrees and graduate degrees are also represented. With 33 programs reporting educational data for staff, 65

TABLE 22

PERCENTAGE OF STAFF BY SEX AND RACIAL GROUP

Demographic Category		Percent	Percent From 9 Site Visits
SEX	Male	13	12
	Female	87	88
RACE	Black	49	44
	White	32	47
	Hispanic	11	8
	Other	9	1

TABLE 23

LENGTH OF EMPLOYMENT BY PERCENT OF STAFF
IN THE NINE SITE VISIT PCC's

Number of Years				
Less than 1	1-5	6-10	11+	Missing
11	42	17	24	6

percent of the employees have less than a college degree, but 56 percent have a high school degree and perhaps some college. Sixteen percent have college degrees and eight percent have graduate degrees. Data were missing on 11 percent of the staff (see Table 24).

TABLE 24

STAFF LEVEL OF EDUCATION

Level of Education	Percent (n=33)	Specialized Degree	Percent (n=33)
Less than high school	9	Child Develop. Assoc.	6
High school (includes some college)	56	Early Childhood Deg. (Associate or Bachelor's)	3
College degree	16		
Graduate degree	8		
Missing data	11		

Only three percent were identified as holding early childhood degrees and only six percent have Child Development Associate certificates. PCC workers have generally not been able to obtain CDA's because competency requirements have not existed for teachers serving children under three. To obtain the current CDA certificate, a teacher must be able to work directly with preschoolers so her competencies can be observed. The CDA for infant workers is now being field tested and some PCC's are involved in that pilot effort.

PCC's are making an effort to employ current or former parents in the program. Twenty-eight percent of the total staff fit this category. Even some PCC grandparents are employed. The range across programs for percentage of staff who are PCC parents is from 0 to 50 percent. Several programs have methods for paying parents as teachers. For example, in Philadelphia parents can take a two-to-three week Substitute Training course in which they are trained to work in the classroom. Then they may serve as substitute teachers and be paid. Participation in the substitute training is a prerequisite for hiring entry-level positions.

Average salaries were calculated for the most frequent categories of employees—teachers and teacher aides—for the nine programs visited. The average salary paid to a teacher is $10,668. This is the amount paid for total months worked, which is usually 10 or 11 months. The range is $7,634 - $22,300. Annualized, this is equivalent to $12,540. Teacher assistants receive less. Actual salaries average $8,169, or

annualized, $9,963. The actual range is $5,156 to $10,597. The annualized range is $6,215 - 11,688. Thus, some annualized salaries are under minimum wage and the average teacher assistant makes about $1,000 above minimum wage in a year. Several program directors complained that low salaries make it difficult to hire qualified staff.

The average staff/family ratio for all PCC's is one staff member to 4.57 families. This includes all staff, not just those directly serving families. This is a measure of the manpower needed to operate programs of this size, purpose and complexity. The staff/family ratio ranges from 2.29 to 9.44.

6. Summary of Community and Organizational Factors

PCC's are about equally divided between urban and rural areas (55% urban), usually operated by a grantee which is a community action agency (56%), and affiliated with a Head Start program also run by the grantee (67%). The programs tend to serve minority (usually black), single mothers who are in their 20's, have less than a high school diploma, and rely on AFDC for support for their child(ren). Overall, the PCC's enroll fewer handicapped children (6.7%) than Head Start requires and have fairly high family dropout rates (from 13 to 333 percent of total enrollment). On average, three-quarters of the ACYF grant is spent on personnel, which is predominantly female (87%), and made up largely of education (44%) and administration (15%) staff. Most of the staff have at least a high school degree and over one-quarter are current or former PCC parents (28%). The major cost finding is that the more children served, the less the cost per child. Average staff/family ratio is 1:4.57 families.

B. EDUCATION COMPONENT

PCC's provide educational services to children in centers and in their homes. They also educate parents and provide opportunities for parent-child interaction.

1. Center-based Programs

Center-based programs are the primary mode for delivering educational services to children (see Tables 25 and 26). All but two programs provide some version of a center program for infants and toddlers. Twenty PCC's provide both home- and center-based educational services to children.

There is considerable diversity in the hours, days, and months of operation. Children may attend anywhere from one to five days a week. They may be present for two hours or six hours and from eight to twelve months.

TABLE 25

EDUCATION PROGRAM MODEL

Model	Total Number
Center Based	14
Home Based	2
Both	18
Combination (same children served in home and center)	2

TABLE 26

NUMBER OF CENTERS PER PCC PROGRAM

Number of Centers	N	%
1	24	70
2	6	18
3	0	0
4	1	3
5	1	3
6	2	6
Total	34*	100

*Two PCC's operate only home-based models.

Centers serve children on the average 4.2 hours per day, with a range from 2.25 to 6 hours. Children attend an average of 2.8 days a week, with a range from one to five days. (When children attend less than five days a week, the program is usually serving different children on different days, thus operating for the full week.) The average number of months attended is 10.3, or 44.6 weeks, with a range from 35-52 weeks (see Table 27).

TABLE 27

CENTER BASED PROGRAM DATA

	Average	Range	N
Hours/day of operation	4.2	2.3-6	33
Days/week	2.8	1-5	34
Weeks/year	44.6	35-52	33
Total contact hours/year	516 (median=453)	117-1,430	30

The concept of parent-child interaction and development of parental skills is, of course, central to the PCC's mission. Twenty-two of the 36 programs require parental attendance with the child and the average attendance in these programs is 8.1 hours per week (range 3-16 hours). Eight programs require some attendance of parents with the child and these programs average 6.6 hours per week. Six PCC's have no parental participation requirement but parents are encouraged to attend in three of these.

Parents usually do not interact with their children the entire time they are in the program. Most often, parents spend an hour or so with the children following arrival and then attend parent classes. They may return to eat meals or snacks with the children later in the day.

Child-staff ratios are of considerable interest in child development programs because they relate to program quality. ACYF has proposed guidelines for these ratios based on child age in the Parent Child Center Program Guidelines.

The child-staff ratio in centers may decrease with older children. Recommended child-staff ratios for children 0-12 months are 2 to 1; for children 12-36 months are 3 to 1; and for children 3 years old are 4 to 1. When parents were not present, the ratios recorded for the PCC's did not meet these guidelines . The nine programs visited have lower child-adult ratios than the other 18 programs reporting these data. Exhibit 5 presents these differences.

EXHIBIT 5

USUAL NUMBER OF CHILDREN TO ONE STAFF MEMBER

Child Age	Actual Number		Recommended Number
	9 Sites	18 Sites	
0 - 1 year	4.3	4.5	2
1 - 2 years	3.7	4.9	3
2 - 3 years	4.0	5.6	3
3 - 4 years	4.4	5.6	4

In one case (Chicago), because of a citywide hiring freeze, there was one worker for eight infants.

In several cases, program staff stated that it was not necessary for them to meet state licensing requirements for child-staff ratio because the children's parents were present.

Class sizes are quite variable within any program because of variations in attendance. Because smaller classes have been found to relate to child cognitive gains, class sizes were examined according to the maximum number of children that could be present. This is the approach used in the PCC guidelines as well. Recommended class sizes for children 10-12 months are eight children; 12-36 months, 12 children; and 3 years, 12 children. This information was gathered only on the site visits. From one-third to 45 percent of the classrooms had more children enrolled than recommended (see Exhibit 6).

EXHIBIT 6

MAXIMUM CLASS SIZE IN NINE SITES

Class Size	Age Group 0-1	1-2	2-3	3-4
7 - 9	5	3	2	4
10-12 *	2	3	3	1
13-15	2	3	4	3
+15	0	0	0	1
TOTAL	9	9	9	9
% of Classrooms with More Children Than Recommended	45%	33%	44%	44%

*Recommended level

As in Head Start, no specific curriculum is required for use in PCC's. The programs use a variety of curricula (see Table 28). Twenty-four PCC's use at least one curriculum developed by someone external to the program. Seventeen of these programs rely on more than one curriculum. Some of the more frequently used curricula include the Peabody Language Kit (3 PCC's), the Portage Guide (7), work by Burton White and Berry Brazelton (3), the Learning Assessment Profile (LAP) (2), and the work of Jean Piaget (2) and Ira Gordon (1). A number of other curricula, both "packaged" programs like the Johnson and Johnson Infant Curriculum, and work by well-known researchers in the field (Merle Karnes, Bettye Caldwell, Francis Palmer), are used. It should be noted that some of the curricula cited are not curricula, but assessment tools, e.g., LAP.

The PCC guidelines state that the program goal for children is to enhance their social competence, taking into account the interrelatedness of cognitive and intellectual development, physical and mental health, and nutritional needs. Programs were asked to describe their

TABLE 28

CURRICULA USED BY PCC

Curricula or Work by	Number of Programs Reporting Use of Curricula*
Peabody Language Development Kit	3
Portage Guide to Early Education Checklist	7
Burton White and Berry Brazelton - Progression Checklist	3
Learning Assessment Profile (LAP)	2
Jean Piaget	2
Others Reported:	
Ira Gordon	
Johnson & Johnson Infant Curriculum	
General Head Start Curriculum for 2-3 year olds	
Traditional Child Development	
Maria Montessori	
Draft PCC Guidelines	
Curriculum Guide for Infants and Toddlers	
Incidental Teaching Approach	
C.D.A. Competencies	
Infant Caregivers Guide (Honig)	
Infant Curriculum (Ball and Alphren)	
Preschool Curriculum by University of North Carolina, Chapel Hill	
Small Wonders Kit I and II	
Little Peoples Workshop	
Merle Karnes' Infant Curriculum	
Betty Caldwell	
Erldine Badger Infant and Toddler Learning Curriculum	
Dallas Schools "Cross Ties Program"	
Palmer Concept Curriculum (integrates works of Eric Erikson and Jean Piaget)	
"Family Oriented Home Based Program (Johnson and Heffron)"	
Un Marco Abierto - bilingual open framework	

*24 programs reported at least 1 major curriculum, 17 of these reported more than 1.

major educational goals for children. Seventy-two percent of the programs responded with some kind of cognitive goal (though 28% did not mention cognitive goals). Most frequently cited as a specific cognitive goal was an emphasis on language development (identified by 13 programs).

Emotional development was noted as a goal by 30 programs (83%), with six not mentioning it. Self-concept development was the most frequently cited emotional developmental goal. Twenty-six programs (72%) identified some form of social development as a goal.

Twenty-four of the programs (67%) noted physical development goals, including fine and gross motor development, perception and development of the senses, and coordination.

Three programs offered very non-specific education goals for the children. Educational efforts in these programs are concentrated on the adults. It is expected that the child will benefit through education of the caregiver.

The programs described a variety of activities for the children designed to help them attain developmental goals. These activities are presented in Table 29.

Thirty-one PCC's use a particular tool to make formal assessments of each child (see Table 30). Several programs use more than one device. The most popular is the Denver Developmental Screening Test used by ten programs. The Learning Assessment Profile (LAP) or the Early LAP for younger children is used by eight programs. The Portage Checklist is used by five PCC's and the Bayley Scales of Infant Development by two.

2. Home-based Programs

Twenty-two of the PCC's serve children in their own homes. Of these, 18 provide home- or center-based services to different children; two are only home-based and in two others the same children receive both home- and center-based services. A total of 1,426 children in 818 families receive home-based services. These children are a slightly younger population than center-based PCC children. From age information obtained from 15 programs, the largest percentage of home-based children (35%) are one-year-olds, followed by two-year-olds (30%), and infants 0-1 year (23%). Only ten percent are over age three (see Table 31). Of center-based children, only 22 percent are one-year-olds; 35 percent are two-year-olds, and only 18 percent are infants. Twenty-four percent are over three years of age.

TABLE 29

ACTIVITIES FOR CHILDREN
OFFERED BY PCC's

Goal of Activity	Examples of Activities	PCC's Offering Such Activities
Cognitive Development	Stories, puppets, finger plays, games, sorting/stacking, recognizing shapes and colors, language activities, science, math, concept building	32
Socio-emotional Development	Group time, individual time, free play, cultural awareness, affection, field trips	28
Physical Development (Gross Motor)	Climbing, crawling, balancing, jumping, indoor/outdoor play	27
(Fine Motor)	Puzzles, pegboards, bead stringing, cutting, scribbling	28
Creative Development (also related to all forms of development listed above)	Art, music, block play, sand/water play, dramatic play, cooking	25
Personal Care	Grooming, toilet training, self-help skills	15

TABLE 30

CHILD ASSESSMENT TOOLS USED BY PCC

Assessment Tool	Number of Programs Reporting Use
Early LAP	2
LAP	6
Denver Developmental Screening Test	10
Portage Checklist	5
Bayley Scales of Infant Development	2
Dial	2
Minnesota Child Inventory	1
Weschsler Screening Test	1
Quarterly Humanics Child Assessment	1
Child Assessment List	1
Child Impressions Checklist	1
Memphis Comprehensive Developmental Profile	1
Daisi	1
Landmark Assessment Tool	1
Parent Child Assessment Form	1
Humanics National Child Form	1
Boyd Development Progress Scale	1
Southeastern Day Care Assessment Tool	1

TABLE 31

HOME BASED PROGRAM DATA

Age Group	Percent (n=15 programs)
0-1	23
1-2	35
2-3	30
3-4	10

The average home visit lasts one hour and occurs almost once a week (3.9 times per month). Most programs bring the children together at the center for a group experience an average of 1.6 times a month. The length of this group activity is usually three hours.

The focus of the home visits is primarily on teaching parenting skills (see Table 32). Eighty-six percent of the 22 home-based programs place this emphasis on home visits. Education of children was identified by 68 percent of these PCC's as the focus, followed by social services (40%) and other parent education (31%). Ninety percent of these programs focus on the parent or parent-child dyad in these visits. Five percent focus on the child and five percent on the family.

Home-based programs serve an average of 55 families with a range from 9 to 137. The average number of employees providing home-based services per program is 5.6. Each staff member serves an average of 11.5 children.

TABLE 32

FOCUS OF HOME BASED VISIT

Focus	Percent of Programs Reporting Focus (n=22)
Teaching Parenting Skills	86
Other Parent Education	31
Child Education	68
Social Services	40

91% focused on either the parent or the parent-child dyad.
5% focused on child and 5% on family.

3. Parent Education and Involvement

The proposed PCC guidlines recommend the following goals in relation to PCC parent education: development of parenting skills, providing opportunities to increase parents' homemaking skills, and enhancing educational and economic status.

Programs identified goals for parents in these broad categories. Thirty-four PCC's cited parental skill development as an educational goal. Included in this goal are efforts to change parental attitudes, awareness or knowledge; improve parenting skills; and promote parents as the first or primary teacher of the child.

Positive parental emotional development is a goal cited by 22 programs. This includes general individual development, self-concept development, parental mental health, and development of decision-making skills. Social development was identified as a goal by 10 programs.

Educational or economic development goals were reported by 12 programs. These include academic training, employment/skill training and employment. Other goals for parents include development of home management skills (mentioned by eight PCC's), use of community resources (10 mentions), health/safety education (7), family life enrichment/ strengthening (4), and cultural/recreational opportunities (3).

Activities planned for the parents paralleled these goals. All but one of the PCC's provide activities that focus on parenting skills or child development. Of these, seven programs reported using the Head Start training program, "Exploring Parenting." Another parenting model used is the "Footsteps" program, in which a series of videotapes are shown and then discussed by the parents. Eleven PCC's provide activities focusing on child abuse and neglect. Five programs offer programs specifically focused on prenatal care. Other types of activities included under the general topic of parenting are family planning, single parenting, programs for teenage parents, extended families, and family life planning.

Though only eight PCC's specifically reported home management as a goal, 30 programs described activities for parents that fall under that category. These include food preparation or nutrition (23 PCC's), sewing or crafts (15), consumer education (11), financial or legal rights education (7), and other opportunities, such as time management, clothing care, and home care and repair.

Also common are educational activities focused on helping parents achieve economic independence. Nineteen PCC's offer opportunities to obtain the GED. For example, the New Orleans PCC offers classes at the "Street Academy" operated by its delegate agency, the Urban League, where parents can obtain their high school equivalency degree. College

courses are offered through five programs and vocational/technical training by four. Three PCC's offer English As a Second Language (ESL), and three provide CDA training.

Employment-related activities are offered by 13 programs. These include job readiness skill training, job/career counseling, and job placement.

Health education activities are widely offered. These include training in preventive health, hygiene, safety and sanitation, mental health, handicapped/special needs children, maternal health, and drug or alcohol abuse.

Several programs reported parent involvement activities, including membership on the center committee or Policy Council and participation in the program evaluation process (using the Self-Assessment Validation Instrument--SAVI) as efforts relating to goals for parents.

The PCC's use several teaching methods with parents. All use traditional teaching methods (e.g., lectures, classes) to some extent. Seven PCC's use audiovisual aids and six use demonstrations. Twenty-eight programs (78%) use some type of active parent participation in the learning process. These methods include discussion groups, role-playing, and observation. Sixteen programs use hands-on experiences, such as sewing or craft-making. An average of 3.6 different teaching methods are used per program.

Ten PCC's offer recreational or cultural activities. These often include field trips. For example, the Glenwood City program took its parents and children to the zoo in Minneapolis on an outing. In New Orleans, the staff wrote and performed a play on coping as a single parent.

In addition to group activities for parents, the majority of the 34 center-based PCC's provide for parent-child interaction time and activities. Twenty-eight programs (82%) have general or specific classroom activities that parents may engage in with their children. Six programs reported no specific planned activities. Twelve programs identified particular activities for parent-child interaction, including cognitive, creative, personal care, social, fine motor and gross motor activities. In Leitchfield, parents spend the first hour with their own children in the classroom. In the infant room CSR staff observed, the teacher introduced various activities and explained how each child could participate at his/her own developmental level. The parents were actively involved in these activities with their children.

4. Parent Involvement

While parents are involved in PCC's as learners, they also are to be involved as decision-makers. In multi-center programs, each center

is to have a center committee, entirely composed of parents who participate in program and staffing decisions. Representatives from each center are elected to serve on the Policy Committee (if applicable) or Policy Council. Each delegate agency is to have a Policy Committee composed of at least 50 percent parents, who assist in the management of the program. At the grantee level, there is a Policy Council, again with a minimum 50 percent parents, that has major management responsibility. The grantee also has a Board of Directors that is the final governing body. The membership of these different bodies must not be entirely the same.

The governing body of greatest relevance to the operation of the PCC is usually the Policy Council. There is considerable variability in the existence and activity of the Policy Councils across programs. In two PCC's, there were no Policy Councils; in another, it had only been recently established, and in a fourth, its function was described as "carrying out the orders of the grantee."

The roles of the councils are fairly broad. Thirty councils (83%) are involved in planning; 19 (53%) in grant application review; 18 (50%) in personnel administration; 15 (42%) in general administration; 10 (28%) in evaluation; 5 (14%) in general program oversight, and six (17%) in other activities. Twenty Policy Councils are involved in three or more of these activities.

5. Summary of Educational Component

PCC's provide educational services to children in centers through home-visiting programs, or a combination of these two approaches. Children attend centers on varying schedules, but usually participate two-to-three days a week for about ten months a year.

Most, but not all, programs require parental attendance with the child. Parents usually interact with their children for some period of the day and participate in group educational activities at other times.

Child-staff ratios are considerably higher than regulations require and class sizes are sometimes larger than recommended.

No particular curriculum predominates across PCC's; instead, a variety of educational approaches are used. Goals for children articulated by programs include emphasis on cognitive, socio-emotional, and physical development. A variety of activities was described to help children obtain those goals.

Almost 1,500 children received educational services in their homes. This is a slightly younger group of children than those in centers. Children are visited about once a week for approximately an hour, and some participate in group activities about once a month. Home visits usually focus on the parent/child dyad rather than just the child and the visits focus on teaching parenting skills.

Parents receive educational services both with their children and in adult groups. PCC's emphasize parental skill development, emotional development, and educational or employment training. Activities provided include workshops in child development, home management, health, nutrition, high school equivalency, and job training. Both traditional and participatory techniques are used in this training.

Parents may also be involved in the PCC as decision-makers through the Policy Council. All but two of the programs have such councils, though there is considerable variation in the degree of activity and the roles among them.

C. HEALTH SERVICES

PCC's provide a range of health services to children and their parents following the Recommended Guidelines objective to arrange or provide for health services for children and pregnant women. Services are most frequently provided to PCC children directly by the program (through contracted and donated services), less frequently by referral. Considerably fewer health services were specifically identified as being provided to parents (see Tables 33 and 34). Programs tend to regard these as part of social service referrals.

Services most frequently provided directly to children are medical examinations or screenings by 81 percent of the programs; nutrition assessment (81%); dental examinations (72%); mental health examinations (67%); diagnosis of handicapped children and treatment of diagnosed conditions (both 53%); immunizations (42%), and other services (25%). These services also are provided by referral from a sizeable proportion of the programs. All programs provide some health services; only one does not provide for treatment of diagnosed conditions, either directly or by referral.

Based on information found in the written materials, much smaller proportions of the programs provide direct services to parents or families. Fourteen percent provide medical or mental health exams, six percent provide dental exams, and five percent provide nutrition assessments. Three percent provide treatment for diagnosed conditions, while 22 percent provide other services. Referrals are provided by 19 percent of the PCC's for mental health exams; eight percent for medical exams; three percent each for dental and diagnosed conditions. In practice, most programs appear to rely on social service worker or home visitor contacts to identify health needs in families who are then referred to appropriate agencies. These referral figures underrepresent program efforts to help arrange needed health service.

The site visit programs were asked what percentage of the children had completed all medical and dental exams and most responded to this question. In five of the programs, 75-100 percent had completed medical

TABLE 33

PERCENT OF PROGRAMS PROVIDING CHILDREN'S HEALTH SERVICES DIRECTLY FROM PCC AND THROUGH REFERRALS

Type of Health Service Provided for Children	Source	
	Direct Services*	Referrals
Medical Examination/Screenings	81	61
Dental Examination	72	44
Mental Health Examinations	67	47
Nutrition Assessment	81	8
Immunizations	42	67
Diagnosis of Handicapping Conditions	53	86
Treatment for Any Diagnosed Conditions	53	78
Other	25	19

*Direct Services are defined as health services provided by the PCC or Grantee through contract with, or direct payment to, service providers and through donated services.

TABLE 34

PERCENT OF PROGRAMS PROVIDING FAMILIES' HEALTH SERVICES DIRECTLY FROM PCC AND THROUGH REFERRALS

Type of Health Service Provided for Families	Source	
	Direct Services*	Referrals
Medical Examination/Screenings	14	8
Dental Examination	6	3
Mental Health Examinations	14	19
Nutrition Assessment	5	0
Immunizations	0	0
Diagnosis of Handicapping Conditions	0	0
Treatment for Any Diagnosed Conditions	3	3
Other	22	25

*Direct Services are defined as health services provided by the PCC or Grantee through contract with, or direct payment to, service providers and through donated services.

exams, and in three of the programs, 50-75 percent had completed these exams. (One program did not report medical or dental information.) In two of the programs, 75-100 percent of the children had completed dental exams, and in three programs, 50-75 percent had completed the exams. Only one program had less than 50 percent completed dental exams, but three programs did not report dental information.

On site the CSR teams observed the bathroom facilities and sanitary procedures for diapering/toileting of the children. Observations were based on guidelines developed by the Center for Disease Control and Dorothy Downes, R.N., in regard to the prevention of the spread of hepatitis and other intestinal diseases in child care programs. The spread of hepatitis usually results from contact with the hepatitis virus in feces as a result of failure to clean the diapering surface and failure to wash hands after diapering. The following items were checked: 1) cleaning the diapering pad and/or use of changing paper over the pad; 2) handwashing of children and adults after toileting or diapering; 3) cleanliness of bathroom; 4) child-sized toilets and/or potty chairs; 5) use of handiwipes or other disposable washcloths for cleaning children in diapers; and 6) use of closed containers for soiled diapers. Of the nine PCC's visited, two had all items listed, two had all but the first item, and five had only the last three or four items listed.

D. NUTRITION SERVICES

The provision of meals and snacks to children and often to parents is an integral component of the PCC program (see Tables 35 and 36). Seventy-nine percent of the 34 center-based programs provide at least two meals a day to children, and fifty-five percent provide at least two meals a day to parents. All center-based PCC's provide at least one snack or meal to children, and all but four provide something to parents. Twenty-three of the 34 programs serving at least a snack (68%) considered this food an important addition to the diet of the parents and children.

E. SOCIAL SERVICES

Most programs employ social services staff members to assist families with problems. These staff members provide services, both directly and through referral to resources in the community (see Table 37).

All of the PCC's refer families to such community services as Medicaid and housing assistance. Ninety-seven percent refer for food stamps and public assistance. Fifty-six percent refer for emergency assistance, 44 percent for counseling, and 22 percent for transportation to agencies. Eighty-three percent of the PCC's directly provide, either regularly or in hardship cases, transportation for families to social service agencies, and 75 percent provide counseling and emergency assistance directly.

TABLE 35

NUMBER OF MEALS AND SNACKS SERVED TO PCC CHILDREN AND THEIR PARENTS, PER DAY PER PCC

Meals Served	To Each Child		To Each Parent	
	N	%	N	%
1 Snack	2	6	1	3
1 Meal	1	3	5	15
1 Snack and 1 Meal	4	12	5	15
2 Meals	9	26	8	23
2 Meals and 1 Snack	17	50	11	32
2 Meals and 2 Snacks	1	3	0	0
No Meals Provided	0	0	4	12
Total	34	100	34	100

TABLE 36

NUMBER OF CENTER BASED PROGRAMS PROVIDING EACH MEAL

Meal	Number of Programs Serving Meal to Children		Number of Programs Serving Meal to Parents Eating with Children	
	N	%	N	%
Breakfast	29	85	22	65
A.M. Snack	7	21	5	15
Lunch	31	91	28	82
P.M. Snack	21	62	13	38

N=34 Center Based

59% of programs involve parents in set up and serving of meals. Most programs do not involve parents in meal preparation because this requires food handlers cards and TB tests.

All center based programs provide at least one meal or snack to children; 88% provide the same to parents.

TABLE 37

SOURCES OF SOCIAL SERVICES AVAILABLE TO PCC FAMILIES

Type of Social Service	SOURCE: PCC/Grantee N	PCC/Grantee %	Community N	Community %
Emergency Assistance/ Crisis Intervention	27	75	20	56
Counseling	27	75	16	44
Transportation to/from Agencies	30	83	8	22
Public Assistance			35	97
Food Stamps			35	97
Housing			36	100
Medicaid			36	100
Other (e.g. adult ed, vocational training, laundry services, translation services, legal services, WIC program, etc.)	21	58	19	53

TABLE 38

PCC PROGRAMS COMPLETING FAMILY NEEDS ASSESSMENTS BY TIME OF PROGRAM YEAR

Time of Assessment	Programs Completing N	Programs Completing %
Within 6 weeks of initial enrollment	23	64
Within first quarter	6	17
After first quarter	5	14
No assessment	1	3
Missing	1	3
Total	36	100

Updates to Family Needs Assessment

	N	%
Program updates assessment	30	83
No update to assessment	5	14
Missing	1	3
Total	36	100

Ninety-seven percent of the programs conduct family needs assessments. Sixty-four percent conduct these at enrollment or within the first six weeks. Seven percent conduct them within the first quarter and 14 percent conduct them later in the year. Eighty-three percent of the programs update the assessments during the year while the remainder do not (see Table 38).

F. SUMMARY OF HEALTH AND SOCIAL SERVICES

Children, not families, are the primary recipients of health services provided by the PCC's. Over 80 percent of the programs directly provide for at least some type of medical and dental screening exams. The provision of these types of services does not uniformly ensure high figures for children with completed physical exams/screenings: after 6-7 months of operation, five of the nine site visit programs had completion rates ranging from 75-100 percent; rates in the other three varied from 50-75 percent. Most of the PCC's visited had completed dental exams on between 50-100 percent of the children; many programs provide these exams only for children 2 years of age and older. Three-quarters of the PCC's serve two meals a day to the children (and over one-half to the parents); the majority of programs regard food services as important to the health of the children and parents. Diapering and toileting procedures in most PCC's visited (7 out of 9) need improvement to help safeguard children's and adults' health.

Social services are both provided by the PCC's (75% or more offer transportation to agencies, counseling, and emergency assistance), and handled by referrals to various agencies. Nearly two-thirds of the PCC's (64%) programs conduct family needs assessments within the first six weeks of the program; the remainder do them within the first quarter (17%), later in the year (14%), or not at all (5%). Most programs update the assessments during the year (83%).

CHAPTER IV.

COMPARISON OF CRITICAL PROGRAM VARIABLES FOR EARLY INTERVENTION PROGRAMS TO PCC PROGRAMS

This study is a descriptive one, conducted at a single point in time, and it does not measure directly the impact of the PCC's on children and families.

In order to focus the study on program factors that most closely relate to positive effects on children and parents, CSR developed a series of proxy indicators of program quality. These indicators, such as staff-child ratio, and use of participatory educational approaches with parents, were developed from two sources. First, a review of the early intervention research literature was made. Second, telephone discussions with ten well-known researchers in this field were conducted. These discussions were designed to obtain professional insights on the critical program factors related to the development of children and parents.

Both personal and telephone conversations with program staff were designed to obtain information on these factors. In addition, observation of program operations also focused on these criteria.

The following paragraphs discuss the presence or absence of these variables in the PCC's.

A. GRANTEE OR OPERATING AGENCY

1. Amount of Bureaucracy and Support of Bureaucracy for the Program.

According to researchers, programs with very large bureaucracies or umbrella bureaucracies that have inconsistent goals with those of the PCC's can be severe hindrances to effective program operations.

PCC's generally do not face these kinds of unsupportive environments. The majority of the PCC's operate in the context of a two or three level bureaucracy. The PCC director reports to the grantee director or to a delegate director reporting to the grantee. The majority of the programs also are affiliated with Head Start. The size of the bureaucracy above the PCC's is generally not great, nor does it appear to create major problems. Occasionally site visited programs stated that they would prefer to operate as their own grantees; however, they also received many services from grantees or delegates. In some cases the Head Start program did overshadow the PCC and often, because of its greater size, demanded a disproportionate share of equally funded resources and staff.

There are some administrative problems which are affecting the day-to-day operations of the programs, such as inadequate facilities.

2. Security and Adequacy of Funding for Program Operations.

The lack of secure and adequate funding for programs has been cited by researchers as a detriment to program operations and staff morale. A few PCC directors complained of previous threats of defunding and the difficulty in recruiting staff because of low salaries (and several staff members complained individually about this across programs). It should be noted that the average total cost per child has risen only $819, or 23 percent, since 1969, according to figures in the Kirschner Associates, Incorporated (KAI) study of the Parent-Child Centers conducted in 1969.

3. Program Location and its Relation to Characteristics of Population Served, Service Availability, Facilities, Travel Time.

The Kirschner study had found significant differences between urban and rural programs, with urban programs having more difficulty securing adequate facilities. In that study, rural programs had more centers, so travel time was lowered.

In the current study, site visitors frequently found facilities too small and inappropriately designed for young children. Several programs did not meet recommended space requirements for indoor or outdoor space, but were exempted from state licensing requirements because parents were present in the building. Five of the nine directors felt their facilities needed improvement, in some cases major improvements.

In contrast to the earlier study, travel time and expenses are large for rural programs, even when there are several centers.

B. PROGRAM DIRECTION AND STAFF

1. Control of Program - Policy Council Activity and Size

The Kirschner study found that PCC's with actively involved Policy Councils were also those that provided more services and more of the services favored by parents. CSR site visitors found that programs with active Policy Councils do appear to provide more services and more of those requested by parents than PCC's with inactive Councils. However, even though Councils are active, control of the program still rests with the staff.

Kirschner also found that smaller Policy Councils (fewer than 20 members) enable more parent control. Based on information from half of the PCC's, the majority have Policy Councils of over 20 members.

2. Staff-child Ratio

Low staff-child ratios are a standard measure of program quality. The ratios are high in the PCC's. For infants, ratios are more than double levels in the Draft PCC Program Guidelines. For 1, 2, and 3 year-olds, actual ratios exceed recommended ratios by one to two children, i.e., the actual ratio for 2-year-olds is one staff to 5.6 children, while one to three is recommended.

3. Training and Characteristics of Director

The Kirschner study found the educational background of the director to be related to services provided and amount of parent control. Directors who had studied education offered more educational services while social work-trained directors offered more casework services, and operated programs that employed fewer parents and had less parent control. Of the nine site visited programs, six of the directors have college educations (five have advanced degrees); three do not. Three have education degrees; two have social work degrees and one has a home economics degree. While only one director has a degree in child development, all nine have had Head Start, nursery school or extensive PCC experience. While only one had training in administration, the majority have been PCC or Head Start administrators. The two programs directed by social workers do not appear to employ fewer parents or have less parent control.

Directors usually assume managerial roles, often having little direct interaction with families or paraprofessional staff. Component coordinators deal most directly with the service staff.

4. Staffing Model and Ratio of Professionals to Paraprofessionals

The Kirschner study found a team approach to service delivery with a high ratio of professionals to paraprofessionals to have many advantages.

The programs visited generally had a hierarchical administrative structure with directors and coordinators supervising teachers and aides. Indeed, 29 percent of the staff are administrators and coordinators. In the classrooms, there were three teachers to every four teacher assistants, but there appeared to be a team approach to working with the families. It was often difficult for observers to distinguish between teachers and aides.

The hierarchical structure created problems in that often coordinators' administrative responsibilities prevented them from observing and supervising teachers.

5. Staff Training

Professional training in early childhood was very infrequent among the staff. Only three percent hold such degrees; only six percent have CDA's.

Very little preservice training is provided, but inservice training occurs at least once a month in most programs.

6. Staff Turnover

The Kirschner study reported a 30 percent level of staff turnover. This is not the situation currently. Only 11 percent of the staff observed had been employed less than a year and 24 percent had been employed in the program over ten years. However, the National Day Care Study found children to perform at lower levels when staff had been employed for long periods of time.

7. Proportion of Paraprofessionals to Professional Staff

The Kirschner study found programs with high ratios of professionals to paraprofessionals to be superior in training, supervision and delivery of services. Current PCC staff are not routinely categorized as professional or paraprofessional, but this information can be deduced. Educational levels of staff show 24 percent to have college degrees and 65 percent to have less than college educations. Thus, the ratio of professionals to paraprofessionals is a little under one to four, a low ratio.

The Kirschner study found hiring parents as staff to be "the most effective way to change child-rearing patterns in a community." Twenty-eight percent of the PCC staffs are now composed of current or former parents.

9. Sensitivity to Family Needs, Attitudes Toward Families

The early intervention researchers felt that sensitivity of staff to families is an important indicator of program quality. While this is a difficult dimension to quantify, based on the nine site visits, the CSR observers felt that staff were generally supportive of and sensitive to the families, especially recognizing the difficult conditions under which many families live. Many of the staff are former or current PCC parents and almost all were residents of the community served. There were isolated incidences in which staff members spoke insensitively or patronizingly about parents, but this was not the norm.

C. DELIVERY SYSTEM

The research differs on the relative benefits of home- versus center-based programs. A mixture of such delivery systems is found in

the PCC's, with many programs (20) providing a combination. The home-based components do tend to serve a younger population, an approach which the research tends to support.

1. Number and Length of Home Visits

The frequency and length of home visits are considered important by researchers. The PCC's perform well in this area. The norm is weekly visits of an hour's length. The inclusion of group experiences for most of these children further strengthens this component.

2. Number of Contact Hours with Child Only, Parent Only, and Parent-Child Together

Research has shown that the amount of contact hours between program and family relates to positive outcomes. Contact hours with children only are highest in center-based programs, and range from 117 to 1560 a year with a median of 453 hours. Parents usually attend the center with their children, but more of their time is spent in parent classes/activities. Parent/child interaction is fairly limited and is usually no more than one hour a day. Though contact is less frequent in home-based than center-based programs, it is expected that the parent will continue the activities after the visitor leaves.

3. Time Devoted to Service and to Other Activities

The Kirschner study found more time spent in direct service provision related positively to other indicators of program quality. Generally, at least 80 percent of the direct service staff's time is devoted to working with families. A four-day program week with one day of training is common. However, 15 percent of the staff is administrative and these individuals rarely work directly with families. Some of the 14 percent who are coordinators spend most of their time with families (social services, health), while others (education) spend most of their time supervising staff.

D. CENTER-BASED PROGRAM

All of the indicators contained in this section are considered important components of the classroom environment by experts and the research literature.

1. Classroom Organization and Materials

Well-organized classrooms include those with defined, multiple-interest centers and accessible, varied, age-appropriate materials. All of the nine PCC's visited had multiple-interest centers in most of their classrooms. Frequently, they were not well enough separated to provide adequate quiet space for children involved in different activities. Generally, the programs did make materials accessible to the

children by placing them within reach (although this varied across some rooms within an individual center). Most PCC's also had sufficiently varied, age-appropriate materials, except for two programs whose supplies were particularly limited.

2. Adult-Child Verbal Interaction

The quality and frequency of adult-child verbal interaction varied considerably, more so within than across the individual PCC programs visited. Sometimes striking differences were observed when moving from room to room in one center. Infant teachers tend to stand out across programs as uniformly providing a lot of verbal stimulation. With other age groups, the picture is not as clear, but teachers of toddlers and 2 year olds tended to engage less frequently in verbal exchanges than teachers of older children. Only one of the PCC's observed showed a rather high level of frequent, developmentally appropriate verbal interaction, often stimulated by the children's activities, regardless of age group.

3. Child-Initiated Activities

Opportunities for children to initiate activities tended to occur during free play and short periods when one group of children had finished a planned activity sooner than another group. In a few centers, younger toddlers were allowed occasionally to join older toddlers in self-selected levels of activity and interest. Overall, two PCC's appeared to consciously place a high value on child-initiated activities and provide extended opportunities for children to choose activities of interest to them.

4. Developmentally Appropriate Activities

Most programs visited did not use developmentally appropriate activities. The major problem lies in attempts to use activities suitable for 3, 4, and even 5 year-olds for children who are only 1 or 2. This is most apparent in activities intended to stimulate cognitive development (language, concepts, and reasoning) and motor development (e.g., art, music, and small muscle). In almost every program, some of these activities were simply too advanced for the age and developmental level of the children involved. Frequently, this problem was compounded by using a group-oriented, structured approach, and not allowing children enough time to complete activities.

5. Patterns of Adult/Child Activity and Control

Patterns of adult/child activity and control appeared to fall into two categories. The most predominant certainly was a positive, low-key approach characterized by verbal (never physical) reminders, gentle admonitions, and diversionary tactics to discipline children and maintain control. Some programs use "Time Out" to isolate an unruly older child for a short time (e.g., 5-10 minutes). Also observed in several programs was a more rigid, highly controlled approach which emphasized

obedience, quietness, strict adherence to the planned activity, and concern with order and cleanliness (e.g., in art activities).

6. Affective Environment

Most programs provided children with an opportunity to develop warm, consistent relationships with adults. There were exceptions in some classrooms, where teachers appeared rather apathetic or brusque, displayed little affection in touch, word, or manner, or were insensitive (e.g., embarrassing a child). But this was not the general rule. By and large, teachers modeled caring, warm behavior with the children, especially with infants. Some exemplary behavior and tactics were used, such as water play to calm an upset child, and reading a story in a quiet corner to a toddler who was too shy to join in a group activity.

7. Treatment of Parents and Children Together

Research shows that programs which focus on the parent and child are more successful in producing cognitive gains than those focusing only on the child. The programs visited varied considerably in fulfilling this approach. In most home visits observed, (and reported by all sites), the focus was on both the child and the parent and their roles in the learning process. In center-based programs, there was more variation. In a few programs staff actively modeled and instructed parents as they interacted with their children. In others, parents were almost ignored as staff concentrated on the children. Overall the focus on the parent/child dyad was stronger in home visits than in the classroom.

E. LENGTH OF PROGRAM INTERVENTION

1. Age at Enrollment and Number of Years' Intervention

The research differs on the benefits of early enrollment: in some studies it appears beneficial, in others it makes no difference. Similarly it is unclear as to whether length of participation produces greater gains. Robert Hess points out, however, that less than one year of intervention cannot have much effect.

Children can be and are enrolled in FCC's at very young ages. Some six-week-old infants were observed, and over a fourth of the children served are less than a year old. With 18 FCC's reporting, the average estimate of the number of years of intervention is 2.2. Given the high family turnover rates, it appears this estimate is not a true mean but instead relates to a core of families who remain with the program.

2. Number of Months Enrollment Per Year

More than eight months of enrollment per year has been found to relate to cognitive gains. Almost all of the FCC's operate more than eight months a year, with the average being 10.3 months.

F. PARENT INVOLVEMENT AND EDUCATION

1. Attendance and Activities

Factors relating to more successful programs include parent attendance, opportunities for parental group activities, collegial supportive training programs, experiential training, and active parent involvement. Some programs used to pay parents a nominal fee to attend the PCC. The experts interviewed and the Kirschner study reported that these fees were sometimes confusing to parents or perceived as bribes for undesirable work.

Surprisingly, parent attendance was not required by all programs, and the degree of attendance and participation varied considerably across programs. It appeared higher when families attended less than every day and when the program was not viewed as a nursery school where children could be "dropped off." Generally the interaction between staff and parents was supportive, although some exceptions to this were observed on site visits.

Educational programs for parents ranged from lengthy lectures to sewing projects in which each parent made something for herself or her child.

Programs are not using incentive payments as they did in the early years, although there are opportunities for parents to receive payments for temporary teaching positions.

2. Improvement in Family Life Status

A few anecdotes collected during the site visits demonstrate how participation in the PCC has changed some parents' lives. In Glenwood City, a teacher aide said that she had heard of the PCC as a place where "you could get your high school diploma and they would look after your kids. I found out there was more to it than that, but I did get my GED and now I'm a teacher aide and driver." In Leitchfield the director described a former parent who said the PCC had helped her to get out of her "shell" and into training and a nurse's job.

G. HEALTH AND SOCIAL SERVICES

1. Provision of Health Services

The research points to the provision of health services, immunizations and the presence of a staff nurse as indicators of program quality.

PCC's are providing a number of health services and making needed referrals. Some programs are much more thorough than others in these efforts and several had delayed examinations and immunizations until

very late in the year. Five of the nine PCC's visited had a nurse on staff. In these programs, the percentages of children with completed physical and dental screenings/exams were slightly higher than in the other programs.

2. Nutrition-Provision of Meals

All programs provide meals or snacks; most provide at least two meals and these are generally viewed as important to family health.

3. Social Services Availability, Staffing and Types of Services

The Kirschner study found PCC's to be providing services to meet families' material and social needs as well as referral and transportation. At the time of that study social services staff accounted for the largest proportion of staff.

PCC's are still providing services to meet material needs and they provide much referral and some transportation. However, the educational staff now comprises the largest proportion of the staff.

All programs had many relationships with other community agencies, individuals and private organizations. They seemed to call upon these resources frequently for services for the program and for individual families.

H. PROGRAM STRENGTHS AND BEST PRACTICES

Staff in 33 of the 36 PCC's identified program strengths and benefits to participants. These were offered during the telephone and on-site discussions with individual program directors. The information has been organized into four categories identified below. Following these descriptions, some of the best practices observed by CSR are presented.

1. PCC Staff Perceptions About Program Strengths and Benefits to Participants

The types of benefits and strengths reported by respondents relate to parents, children, staff, and program services or special features (see Table 39). Each of these responses was offered by the respondent to a general question regarding benefits, rather than by checking items on a closed-ended questionnaire. The benefits and strengths are described below.

a. Parents

A major perceived program strength is the level of parent involvement and participation (45% of the 33 PCC's). One respondent spoke of cultivating a sense of parents' ownership and responsibility for what goes on in the program. Good parental participa-

tion is promoted in part by supporting activities in which parents are interested and by encouraging parents to be involved in center committees or parent groups. Another 15 percent of the programs regard their involvement of fathers with particular pride.

A primary benefit to parents is better parenting skills (36% of the 33 PCC's). Specific references were made to improved disciplinary techniques, better understanding of child development, emphasis on the parents as their child's first teacher, and appreciation of the child's own capabilities.

Educational and employment opportunities for parents is another area emphasized. Academic training, such as the GED or ESL classes (15%), opportunities to develop job skills or obtain vocational training (21%), and actual employment (12%) constitute very real gains in parents' lives.

Individual and social development of the parents was identified as a benefit by a number of programs (30% and 27%, respectively). Among the changes mentioned were improved self-concept and the socialization available to help overcome parents' isolation.

Other types of benefits to parents include learning home management skills (18%), such as sewing, cooking, and budgeting, the strengthening of family life and development (15%), and use/knowledge of community resources (15%). These aspects are seen as encouraging self-sufficiency and helping to stabilize the family unit.

b. Children

The development of the child was cited as a benefit by 18 percent of the programs. This covers any of the four major developmental areas (cognitive, emotional, social, and physical). Programs pointed to the opportunity for socialization, improved LAP scores, improved self-confidence, and the development of self-help skills.

c. Staff

One overall program strength mentioned by many respondents relates to the staff. Staff accessibility and rapport with families (27% of the 33 PCC's) was cited. Being available to and caring about the parents, having good communication skills, and engendering a mutual respect were seen as highly important in operating a good program. The quality and stability of PCC staff is another critical factor identified by several programs (18%). Well-trained, qualified staff who stay with the program are an enormous asset. Finally, staff use of community resources (18%) constitutes a program strength. Having a network of resources

TABLE 39

PROGRAM STRENGTHS/BENEFITS TO PARTICIPANTS
(Based on 33 PCC's reporting)

	N	%
Parents		
Parent Involvement/Participation	15	45
Fathers' Groups/Involvement	5	15
Parenting Skills/Courses	12	36
Academic Training/Educational Opportunities	5	15
Employability/Training Opportunities	7	21
Employment	4	12
Individual Development (including self-concept)	10	30
Social Development/Socialization	9	27
Home Management Skills/Courses	6	18
Strengthening Family Life/Development	5	15
Use/Knowledge of Community Resources	5	15
Children		
Child Development (cognitive, emotional, social, and physical)	6	18
Staff		
Accessibility/Rapport with Families	9	27
Quality/Stability	6	18
Use of Community Resources	6	18
Program		
Health Services/Education	12	36
Handicapped/Special Needs Services	3	9
Nutrition Services/Education	5	15
Social Services (including assessing family needs)	4	12
Community Relationships/Network of Resources	5	15
Specific Programs (e.g., Infant, Grandparent, Career, Expectant or Teen Mothers, Homemaker Clean-Up, etc.)	8	24
Facility	3	9
Other (e.g., toy lending library, program curriculum, support system to young mothers, case conference technique, in-service training for staff, bi/multicultural population, etc.)	8	24

available is not enough; program staff need to know who can provide services and how to tap the appropriate resources to serve PCC families.

d. Program Services/Features

This general category includes a range of services and specific features. Most frequently identified were health services and education (36% of the 33 PCC's). Obtaining needed medical services for very young children promotes their physical well-being and provides the opportunity for early detection and treatment of problems. One respondent commented that, without the PCC, 90 percent of the children would not have physical exams or brush their teeth. Nutrition services/education (15%) and handicapped or special needs services (9%) were also cited as program strengths. Some staff spoke about changes in parents' eating habits, for example, or about the provision of specialized treatment for handicapped children who otherwise would not receive such services. Social services, including a complete assessment of family needs early in the program year, is another program strength (12%).

Specific types of programs were identified by nearly one-quarter of the PCC's responding (24%). These programs include grandparent, expectant mothers, and career programs. One PCC even has a homemaker clean-up program (cleaning supplies provided every three months to help make the home environment healthier for children and families). Facilities were cited as a strength by nine percent of the programs. Finally, 24 percent of the PCC's pointed to "other" strengths, such as having a toy lending library, providing a support system to young families, and using a case conference technique for high-risk families.

2. Best Practices Identified by CSR

This section presents some of the best practices observed in the nine PCC's visited by CSR teams. These practices illustrate program effectiveness in working with children and families in some of the areas just discussed. The programs are identified by the city where the central office is located.

Chicago, IL

- The infant teacher's skill in creating a warm and responsive atmosphere, in caring for and stimulating the babies, and in guiding the mothers as they interact with their children.
- Very pleasant and developmentally positive mealtimes with children, teachers and parents.
- Very active Policy Committee.

- Availability of staff to parents; provision of direct counseling.

- Excellent community relationships and cooperation with community agencies.

Glenwood City, WI

- Written agreement with the parents which clearly states the level of participation and other program expectations in order to enroll and remain in the PCC.

- Imaginative, nourishing menus (e.g., bagels with ricotta cheese and blueberries; poached eggs in toast cups).

- Well-organized, attractive, and spacious classrooms in the East Luck Center.

- Comprehensive home visits with particular attention to social service needs.

- Employment of parents as staff (26%).

- High level of parent involvement and interest in parent education activities; good staff/parent comraderie.

Grandview, WA

- Provision of diagnostic and treatment services to a large number of handicapped children (28 or 13%), many of whom have severe impairments, by utilizing (and transporting to) appropriate resources in the state.

- Outreach to new families; advocacy for those enrolled.

- Arranging types of social services particularly relevant to the disadvantaged farm laborers who make up the population served by the program.

- Employment of parents as staff (21%).

Huntington, WV

- Employment of parents as staff (43%)

- College courses paid for staff after six months' employment in the program.

- Qualified, knowledgeable handicapped services specialists available to provide/arrange diagnostic and treatment services.

- Developmental histories taken yearly, even for reenrolled children, and provision of physical exams/screenings.

- Active, involved Center Committees/Policy Council.

Leitchfield, KY

- Outstanding parent/child interaction sessions in the infant room (lots of stimulation, affection, and appropriate developmental activities).

- Excellent mainstreaming of handicapped children.

- Good fine motor and reasoning activities in toddler rooms, provided in relaxed, warm atmosphere.

- Active pursuit and follow-up (with complete documentation) of social services needed by PCC families.

- Sewing classes for mothers showed high interest and enjoyment levels among participants and resulted in both a learned skill and useful products (e.g., clothing for children).

- Use of VISTA volunteers to conduct a number of parent education classes, e.g., sewing (this resource may not be available next year, however).

Louisville, KY

- Emphasis on the process, not product, in an art activity for one group of toddlers (allowed for individual expression and exploration, unlike most other similar activities observed anywhere).

- Infant room with carpeted play pit, including steps and tunnel—excellent for quiet and active times.

- Employment of parents as staff (32%)

- Wide range of classes and activities for parents

- Active, involved Center Committee/parent groups.

New Orleans, LA

- Arrangement for G.E.D. classes at Street Academy

- Requirement for completed physical exams prior to enrollment.

- Good, affective environment and positive reinforcement in the infant room.

- Strong relationships with local businesses and organizations that donate supplies and services for programs.

Oakland, CA

- Strongest emphasis seen on educational and career development of the parents: G.E.D. and ESL classes on-site, job training through both the PCC and community resources.

- Teen parent program, in collaboration with Oakland Public Schools, which enables mothers to complete formal education and also learn about good child-rearing practices.

- Model for written and implemented sanitary procedures.

- Emphasis on process, not product, in art activities.

- Excellent outdoor playground.

- Children's activities appropriate to their developmental levels and consistent with good early childhood practice.

- Employment of parents as staff (37%)

- Active parent involvement and cultivation of sound decision-making skills relating to the program and the individual.

Philadelphia, PA

- Excellent home visits observed in home-based option: parent/child focus, appropriate developmental level activities, involved parent, follow-up on both social services and developmental needs, collegial relationship between staff and parent.

- Substitute Training Program which includes child development, based on the premise that even the cook's assistant or bus driver is in contact with children and needs some basic education in this area; this program also helps participants find employment elsewhere.

- Employment of parents as staff (50%)

- Very active Policy Council

- Nutritious, attractive, and varied meals.

I. PROGRAM CHANGES DESIRED AND LIMITATIONS ON EFFECTIVENESS

From the written materials and discussions with program staff, specific changes desired or needed in the program were identified in 33 of the 36 PCC's. These comments provide some indicators of concerns local staff have in operating their program. This discussion is followed by limitations on program effectiveness from CSR's perspective.

1. PCC Staff Perceptions About Program Changes Desired

The changes recommended by PCC staff are delineated under four major topics: facility/equipment; staff; PCC program; and Head Start program (see Table 40). They are described below.

a. Facility/Equipment

In nearly 40 percent of the programs, improvements to the indoor space/facility are needed. Only one of these 13 PCC's has plans to make the changes by fall of 1984. Half of the remaining programs feel the need for a new or additional building; the others want expanded or renovated space in their existing facility. While more adequate classroom space is frequently mentioned, other needs include parent activity rooms, offices, and more adequate kitchens. More or improved outdoor play areas were mentioned by 12 percent of the programs responding. It is apparent that indoor space is a more pressing concern. About one-quarter of the PCC's (24%) reported that specific types of equipment (plumbing or heating systems, kitchen appliances, playground equipment, etc.) and vans for transportation need to be replaced or obtained.

b. Staff

A number of program directors (39%) keenly feel the need for additional staff. Among the types of staff specified were handicapped specialists, mental health staff, social workers, and teachers. Some of the directors said they wished to hire better-qualified staff but were hindered by the low salaries offered by the program. Other issues related to the staff include provision of more training (15%), usually in the health/handicapped/mental health areas, the need to increase salaries (12%), and to reduce the staff workload (18%). This latter concern emanates from what appears to be a real overextension of staff because of their multiple responsibilities, which prevent them from serving children and families in the ways and depth needed.

TABLE 40

PROGRAM CHANGES DESIRED
(Based on 33 PCC's reporting)

	N	%
Facility/Equipment		
Improve indoor space	13	39
Add/replace equipment/vehicles	8	24
Improve outdoor space	4	12
Staff		
Add staff	13	39
Reduce workload/have more time to do job well	7	21
Provide more training to staff	5	15
Increase salaries	4	12
Hire better qualified staff	2	6
PCC Program		
Expand program/serve more families	14	42
Develop/add specific programs/features	12	36
Increase/strengthen parent attendance and participation	9	27
Amend enrollment practices/requirements	5	15
Expand health education/services and social services	5	15
Improve recordkeeping (including follow-up)	4	12
Other specific to individual PCC (e.g., improve/expand transportation services, become licensed, increase budget to better serve families, become own grantee or delegate agency)	10	30
Other related to PCC's nationally	3	9
Head Start Program		
Obtain funding for HS program/additional classes	4	12
Other (e.g., change HS to serve 0-5; separate HS staff and/or HS program from PCC; get priority for PCC children; incorporate parent involvement from PCC into HS)	5	15

c. PCC Program

Over 40 percent of the programs would like to expand their local operations by serving more families. This would require increased funding. But the recommendation is testimony to the effect of the PCC's on families as seen by staff and others affiliated with the programs. The development or addition of specific types of programs or classes is another area needing attention (36%). Among those identified, more related to parent training or education than to children's programs. Prenatal classes, job training, sewing and food preparation classes, teenage mother program, training lab, family planning, legal services, and GED classes were suggested for parents. The addition of a home-based option, increasing the number of infants served in home-based, and expanding a sibling program were suggested for children.

Increasing or strengthening parent attendance and participation is an expressed concern in over one-quarter of the PCC's (27%). Besides getting more parents to attend the center or particular classes (e.g., GED), several of these programs stressed the need for more parent-child interaction sessions during the day or for increased contact hours at the center. Two programs with home-based options felt those parents need to have more group experiences in the center. It was also suggested that more fathers be involved and that parents participate more in program planning.

In a few programs (15%), changes in enrollment practices and/or requirements were desired. One change related to requiring parents to obtain children's physical exams prior to the start of classes to reduce staff effort spent in obtaining them; another pertained to enrolling fewer high-risk families. One director felt that the participation requirements should be reduced to help overcome underenrollment. The last suggestions came from some staff in one program who felt that income guidelines should be removed to avoid the stigma associated with an only low-income program and that children of staff should be allowed to enroll when no other options are available.

Fifteen percent of the programs recommended the expansion of health-related education/services. Specifically mentioned were educating parents to use available resources, providing clinical services to parents, increasing emergency funds for families' needs, and providing more social services directly to families. These changes are needed primarily because of perceived gaps or delays in the community service delivery system.

Twelve percent of the programs identified improved recordkeeping as a need and all are working on this. One reference was to a more centralized recordkeeping system, but the remainder addressed specific component areas, such as refining the tracking system for

children's health services, keeping better records in the food program, and improving the family needs assessment records and follow-up.

A cluster of "other" changes specific to only one or two PCC's was mentioned by 30 percent of the programs. These comments included improving/expanding transportation services, being licensed, increasing the budget to better serve families, doing a community impact study, and becoming own grantee or delegate agency.

A few programs (9%) identified changes which relate to the PCC program from a national level. First, one director expressed the need for greater understanding of the PCC goals and program and the need for program expansion. (This sentiment was echoed during several site visits, even though those programs are not counted here.) Another recommendation involved revising the PCC guidelines to eliminate some "shades of grey." (Related comments during informal conversations with other PCC program directors emphasized the need to make the PCC guidelines "official" like the Head Start Performance Standards.) One grantee executive director said a PCC should be established in every low-income community, because it is the vehicle to help generate concrete changes in families' lives.

d. Head Start Program

This last section deals with changes related to the Head Start program. Twelve percent of the PCC's would like to obtain money to implement or expand Head Start in their programs. Three out of these four PCC's do not have any Head Start program available to their PCC families and are concerned about what happens to children during the years between leaving PCC and entering public kindergarten.

Several other PCC's identified other types of Head Start-related changes (15%). These comments varied considerably: changing Head Start to serve 0-5 year-olds; separating HS staff responsibilities or the HS program entirely from the PCC; getting priority for PCC children in HS; and incorporating the level of parent involvement found in the PCC into HS.

2. Limitations on Program Effectiveness Identified by CSR

a. Insufficient Number of Classroom Staff

Programs rely on the presence of volunteers and attending parents to provide an adequate number of adults in individual classrooms. The problem with this approach is that volunteers are not always reliable and the parents are in the classrooms for only short periods. The average child/staff ratios found on site were from one to two adults short of the recommended minimums in the

PCC guidelines (depending on the age group), and the data from some programs (see Exhibit 5) indicates the situation is even more acute. The shortage of adults is potentially dangerous and negatively affects the nature and quality of the children's time in the classroom.

b. Lack of Developmentally Appropriate Curriculum and Activities

A number of programs use assessment tools as curricula. This reveals a misconception about the nature and purpose of a curriculum and leads to "teaching to the test." Compounding this difficulty is a tendency to utilize approaches and activities for Head Start age children, somewhat "watered down" to accommodate younger children, in the PCC's. The result is developmentally inappropriate activities and techniques for many one- and two-year olds.

c. Inadequately Trained Classroom Staff

Related to the aforementioned topic is inadequate training for many classroom staff. Some program directors cited two problems connected with training: 1) little money for any kind of training, and 2) the absence of nearby colleges or other resources where infant/toddler early childhood specialists are available. These difficulties perhaps can best be addressed by the regional and national offices. The CDA credential for infants and toddlers is in the field testing stage; when finally available it may help overcome deficiencies in training for staff working with these age groups. However the fact that only 6 percent of the staff in 33 PCC's have CDA credentials for 3-5 year old and still fewer (3%), an Early Childhood Education degree, does not encourage the view that formal credentialing will fill the very large need for training in this area.

d. Overburdened Staff, Particularly Component Coordinators

Besides the problem of too few classroom teachers generally for the number of children attending, other staff in the PCC's visited tend to have more responsibilities than they can be expected to handle on a consistent basis. Other responsibilities prevent coordinators from observing in classrooms, providing modeling for, and training teachers and parents. This was particularly true in certain programs also having Head Start programs, where Health, Social Services, and Education Coordinators serve both the PCC and Head Start. The sheer numbers of children and families involved, with the attendant volume of records and need for continual updates/follow-up, impairs the capability of even the most committed, hardworking person.

e. Lack of Timely Physical Exams/Screenings, Diagnostic Services, and Family Needs Assessments

Most programs do not require recent physical exams for children prior to enrollment in the PCC, so that these services must be arranged or continued follow-up with the parents is necessary to assure that the exams are done. Too often many children do not have all screenings completed until the last months in the operating year. This poses a potential health hazard, reduces the opportunity for early detection of health problems, and expends staff time in follow-up which might be utilized in other areas.

Similarly, diagnostic services for suspected handicapping or other conditions often occurs late in the year, especially when the physical exams are a primary source for detecting problems. This delay means that only limited time is available for handicapped children to benefit from an appropriate intervention approach.

The majority of PCC's (64%) complete family needs assessment within six weeks of initial enrollment. The remainder do it later or not at all. Without an early assessment, no program can arrange the types of services needed by its families in a timely fashion. This assumes that the assessments are thorough and that there is active follow-up. Unfortunately, this assumption does not always hold true, at least among some programs visited. Making referrals, following up with the families and agencies, and documenting contacts is a time-consuming task. If programs are short on staff, if staff are not well-trained in the procedures or if they are somewhat indifferent to the needs, the families "fall through the cracks" and a significant opportunity to help effect changes in families' lives is lost.

f. Inadequate Facilities

This difficulty has been raised in previous discussions. Among the programs visited there were 16 centers of which 13 were seen. Only seven centers had what would be regarded as adequate space in all classrooms for the number of children and parents attending (1 in Leitchfield, 2 in Glenwood City, 1 in Oakland, 2 in Grandview, 1 in Huntington). Limited office space (or none, with desks in hallways), small parent activity rooms, lack of conference or testing rooms, and little kitchens (e.g., 8 x 8) at various centers compound the difficulties in operating an effective program.

g. Inadequate Sanitary Procedures/Facilities for Diapering/ Toileting

Careful sanitation procedures in diapering and toileting children are a neglected area. Only two of the site visit programs had clean, well equipped bathrooms and implemented good practices in changing diapers, cleaning the changing area and potty chairs, disposing of waste, and handwashing by both staff and children. The obvious risk in not instituting such practices is contamination and spread of disease among children and adults. The obvious cure is educating staff and parents in the necessary procedures and seeing that they are implemented.

h. High Turnover Rate Among Families Served

This problem has been raised in earlier discussions. The nine PCC's visited had an average of 56 families, or 68 percent of their enrollment, terminate during the program year. (Omitting the two programs with enormously high rates—90% and 333%—reduces this figure to 27% turnover rate in seven PCC's.) This level of turnover in families seriously impairs a program's ability to provide sustained benefits to families. Considerable staff time is required in terminating and then recruiting/enrolling new families.

i. Lax Participation Requirements

Some programs do not require the parents to attend every time their child comes to the center. Others do not provide for a planned parent/child interaction session (besides arrival/departure or mealtimes) each time the families are in the center. It seems apparent that there will be little impact on parents when they are absent. Conversely, a few programs have some parents who remain for a number of years through several children. In a sense, these families monopolize slots which might go to new enrollees who could benefit from program exposure. An argument could be made for focusing on first time mothers or limiting time in the program for each family regardless of the number of children in the PCC.

j. Inadequate Funding for Operating Dual Programs

The PCC's essentially run two programs, one for parents and another for children. Parents are helped to become better parents, to achieve economic self-sufficiency through educational and career development, and to strengthen their own personal growth. Children are helped to develop their potential in the cognitive, emotional, physical, and social spheres. These dual missions are funded, on average, at $341,454 (PA 25 grant) per program. The PCC's appear to be accomplishing both missions with a modest outlay of funds. Limited funds affect facilities, type and number of staff, number of children who can be served, and the availability

of services. The impact on health services and staff training ha been addressed. There is also insufficient emphasis placed on parenting skills/child development classes and educational and career development for parents. Site visit teams noted that some programs do not provide organized, sustained, child development education for parents. Educational progress was quite limited in some instances. (For example, programs with GED classes offered on-site appear to produce more graduates than those whose parents must go elsewhere.) More information is needed before attributin these limitations to funding levels. They do illustrate the complexity of operating two programs (children and parents) on a low budget.

BEST COPY AVAILABLE

CHAPTER V.

CONCLUSIONS

In general the Parent Child Centers have many of the characteristics of quality child development programs, but show a need for improvement in several areas. The programs are serving a large number of children and families at low cost. The clients being served are low income families with multiple needs. A variety of innovative approaches is used to respond to these needs and there is a clear emphasis on moving families out of dependency. Programs often operate under less than adequate conditions and are able to do so because they have highly dedicated staff. While there are always problems in human service programs, the ones identified can be corrected through training, technical assistance, and implementation of proposed regulations.

The following sections present conclusions, major problems, and options which ACYF may want to address in the coming years.

A. COMMUNITY AND ORGANIZATIONAL FACTORS

1. Population Served

The Parent Child Centers are well distributed across the country in both urban and rural communities. They serve disadvantaged and minority clients in proportion to their representation among American poor families.

The highly transient nature of the service population is often a problem in programs serving very low income groups. In some PCC's, there is a veritable revolving door as families move in and out. It is unlikely that the programs can have much effect when the duration of service exposure is so short.

Possible steps that can be taken to assuage this situation:

- Use contracts with families to clearly delineate participation requirements prior to enrollment and to obtain a commitment to the program. With teenage mothers living with parent(s), consideration should be given to having grandparents as parties to the contract as well.

- Target a needy, but less transient population, i.e., mothers in their early twenties, rather than teenagers, who are more likely to remain with the program. While teenage mothers may need the services, if they participate for only a few weeks they will receive little benefit. It would be more cost-effective to serve a more mature mother who would stay for a year.

- Reduce the number of multi-problem, high-risk families served which the programs admittedly serve less effectively, but which require a disproportionate share of staff time.

- Establish a maximum length of stay, regardless of number of children, to avoid some families' monopoly of slots and dependency on the program.

- Require current physical exams and immunizations for children prior to enrollment to ensure timely diagnosis and treatment of children and to reduce level of staff effort expended in this area.

- Concentrate services to families at and immediately after enrollment especially family needs assessment and health screening other than physicals. This will avoid loss of these services to families who later drop out and should also invest and involve families in the program early on.

2. Organization and Management

The programs have fairly simple organizational structures with one to three bureaucratic layers. Some programs are more complex due to multi-centers or multiple programs, and in these instances directors may be managing million dollar plus operations. In a few cases, the program has outstripped the management capacity threatening its effectiveness. Also, a few programs are experiencing severe management problems and clearly need some technical assistance. Regional Office staff may want to review directors' capacity to manage the more complex programs and to determine if resources are adequate.

This study was not designed to examine costs and expenses in depth. However, our quick review shows that the program costs appear reasonable. Although there are individual differences in salaries for similar jobs, no salaries are particularly unreasonable given location and responsibilities. On the contrary, service staff, especially teacher aides, are paid low salaries. Indeed, additional funds are needed to attract staff trained in child development.

Our impression is that some contributions to some programs' non-Federal share were not valid. In contrast, some programs were not counting local resources as in-kind when they could. If verification of this share is a priority for ACYF, it appears that additional work is needed. Technical assistance could be made available to programs to help them determine their local share and become aware of other Federal resources.

Clearly more training is needed in developmental activities for children under three. Trainers (whether coordinators or consultants) should observe current practices and base their training on observed needs. Training is also needed in how to train parents in child development especially through work with the children in the classroom.

Many PCC's are serving neglectful and abusive parents often by court request where families have come under state jurisdiction because of child abuse or neglect. This is a clinical population for which special intervention is required. Most PCC staff are not trained in this area. Working with such parents is a demanding task and requires special knowledge, expertise, and an ability to deal with the conflicting attitudes staff may have about such parents. ACYF may wish to consider the appropriateness of service to these families, given their relatively small numbers.

According to the proposed PCC guidelines, programs are understaffed for the number of children served. This is a serious and potentially dangerous situation. Using parents to raise the ratio is not an adequate solution. Additional teachers should be hired or enrollments reduced to bring ratios to the recommended levels.

B. EDUCATION COMPONENT

The educational programs in the home-based models possessed almost all the characteristics of quality identified in the background report. We observed that visits focus on parent-child dyads, usually provide age appropriate activities, reinforce parent efforts, provide models for parents, and suggest ways for pursuing activities during the week.

The center-based programs had fewer of the characteristics of effective programs, although we observed some excellent ones. A major constraint on programming is inadequate, cramped facilities.

Efforts should be made to assist programs in obtaining adequate facilities. Inappropriate activities for young children, inadequate staff-child ratios, and lack of verbal interaction also create problems. Affect between staff and children was generally good. Most programs developed daily and weekly classroom plans (though plans were often sketchy). There is a good focus on developing individual plans for children; although in some cases this was overdone with assessment becoming an end in itself. More comprehensive class plans and less rigorous individual plans would be preferable.

Parent/child interaction time is often short or, in some cases, nonexistent. This situation should be rectified so that there is always a minimum of an hour per day alloted for parents to participate in developmental activities with their children.

C. PARENT EDUCATION

There is a variety of program foci, parent activities and levels of participation across programs. Even though parent involvement is integral to the program, parents do not always participate. The parent participation requirements should be strengthened.

Programs still rely heavily on traditional educational methods even though many parents have shown their distaste for school-like environments by dropping out of high school. Some parent education programs observed were excellent; others were very poor. Parent education activities should be responsive to parent interests and expressed needs and should concentrate on the use of non-traditional, participatory methods.

D. HEALTH SERVICES

The PCC's are providing health screening and treatment to children and, to a lesser extent, their parents. The completion rates for children's health screenings/exams are not as high as those found in Head Start. Examinations and immunizations often do not occur until mid-year, uncovering problems which could have been diagnosed earlier.

Recent research has shown that the spread of hepatitis in child care agencies can result from inadequate diapering practices. Sanitation practices adequate to prevent the spread of intestinal diseases are generally not being followed, particularly with respect to toileting and diapering. Staff and parents could benefit from training in good sanitary practices.

E. NUTRITION

The nutrition program is a strong component of most PCC's. Several nutritious meals and snacks are provided to children and parents though in a few programs meals are not approved by a qualified nutritionist and did not appear balanced. Exposure to new foods and methods of meal preparation are also a part of the program.

F. SOCIAL SERVICES

PCC's are assisting families in meeting their own basic needs and using community resources. The PCC staffs have developed broad networks of community resources and help families to obtain access to them. Family needs assessments are usually conducted but they are often done late in the year. Home-based families seem to receive social services on a proactive basis because of their consistent, individual relationships with home visitors, while center-based families seem more likely to receive services in response to specific requests for assistance.

Needs assessments would be more effective if conducted at enrollment and up-dated periodically. Social service plans for families should be based on the needs assessments and should identify family goals toward which services and efforts will be directed. This will provide more direction for staff and families and focus on prevention and development rather than crisis intervention.

G. PARENT INVOLVEMENT

Policy Councils are not very active in many of the PCC's and, in fact, some programs do not have them.

Directors could be advised to form Policy Councils which adhere to the recommended activities and responsibilities. Directors may need assistance in forming these Councils.

H. PCC GUIDELINES

The proposed PCC guidelines that ACYF developed and that were reviewed by the PCC Directors are very comprehensive. They address many of the above problems and if promulgated would assist in providing remedies for these problems.

I. PROGRAM EVALUATION AND MONITORING

This study delineates some characteristics of all PCC's and describes the operations of nine of them in greater depth. Individual problems and strengths have been identified for these nine in particular, but clearly all 36 could benefit from similar scrutiny and subsequent technical assistance. All 36 should be evaluated, but special attention should be paid to certain programs not visited where telephone interviews revealed serious administrative problems.

Not since the PCDC experience has an impact evaluation of the PCC's been conducted. One is needed to determine if these programs are having positive developmental effects on children and families. Such a study should examine effects on the cognitive, socioemotional, and physical development of children and on the child-rearing attitudes, abilities and life status of parents.

Many PCC's and Head Starts have been combined administratively with successful results. Generally PCC's benefit from these expanded resources, although there have been problems in some cases. If Head Starts are offered the option to expand by initiating a PCC, care must be taken to insure that programs are designed for infants and toddlers and not just "watered down" Head Starts.

The potential benefit to families, through PCC, is apparent. If the program is expanded to more communities, more families would be helped. However, CSR does not recommend wholesale expansion of the program until some of the problems cited herein have been addressed by training and technical assistance. (There are some excellent individual programs that could serve as models for expansion.) One of the major difficulties is the lack of trained infant workers and until the CDA credential for infant workers is operationalized, this situation is not likely to improve.

Many PCC's have model components that should be shared with the other programs. A national conference focusing on the "best practices" identified here would help to transfer the approaches between programs, assist in general sharing of problems and solutions, and reduce the frequently cited feelings of isolation among PCC directors.

APPENDIX A

PARENT CHILD CENTERS

Region	
I	Boston Parent Child Center Dorchester, Massachusetts
I	North East Kingdom Community Action Child and Family Development Program Newport, Vermont
II	Newark Parent Child Center Newark, New Jersey
II	Hunts Point Parent Child Center Bronx, New York
III	Martin Luther King, Jr. Parent Child Center Baltimore, Maryland
III	Parent Child Center - Southwestern CAC, Inc. Huntington, West Virginia
III	Philadelphia Parent Child Center, Inc. Philadelphia, Pennsylvania
III	Washington, D.C. Parent Child Center Washington, D.C.
IV	Edgewood Parent Child Center Atlanta, Georgia
IV	Chattanooga Parent Child Center Chattanooga, Tennessee
IV	Whitfield Parent Child Center, Inc. Dalton, Georgia
IV	South Central Human Resources Agency Parent Child Center Fayetteville, Tennessee
IV	Jacksonville Parent Child Center, Child Development Services Jacksonville, Florida
IV	Breckinridge-Grayson Programs Parent Child Center Leitchfield, Kentucky

APPENDIX A

PARENT CHILD CENTERS
(continued)

Region	
IV	Louisville-Jefferson County CAA Parent Child Center Louisville, Kentucky
IV	Chatooga Parent Child Center Summerville, Georgia
IV	Birmingham Parent Child Center Birmingham, Alabama
V	Chicago DHS Garfield Parent Child Center Chicago, Illinois
V	Wabash Area Development Parent Child Center Mill Shoals, Illinois
V	Cincinnati/Over the Rhine and Heinold Parent Child Center Cincinnati, Ohio
V	Hough Parent Child Center Cleveland, Ohio
V	Detroit Parent Child Center Detroit, Michigan
V	West Central Wisconsin CAA Pre-School Education Program Glenwood City, Wisconsin
VI	Urban League Parent Child Center New Orleans, Louisiana
VI	Dallas County CAA Parent Child Center Dallas, Texas
VI	Project Head Start Parent Child Center Houston, Texas
VII	Human Development Corp. Parent Child Center St. Louis, Missouri
VII	Head Start Child Development Corporation Omaha, Nebraska

APPENDIX A

PARENT CHILD CENTERS
(continued)

Region	
VIII	Child Development Services - Otero Junior College LaJunta, Colorado
IX	Harbor City Parent Child Center Harbor City, California
IX	Parent Child Center of Kalihi, Inc. Honolulu, Hawaii
IX	Oakland Parent Child Center Oakland, California
X	Parent Child Services, Inc. Portland, Oregon
X	Yukon-Kuskokwim Parent Child Program Bethel, Alaska
IMPD (INDIAN)	Oglala - Sioux Tribe Early Childhood Learning Program Pine Ridge, South Dakota
IMPD (MIGRANT)	Development of Human Resources Grandview, Washington (Moved to Region X as of July 1, 1984)